The Populist Radical Right in Government:
The Effect of the Populist Radical Right on Health Policies in Western Europe

by

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Dedication

To those unable to share the joy of this degree with me in person.

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Table of Contents

List of Tables

List of Figures

List of Appendices

Abstract

Health policy research tends to focus on medical care practices and disease prevention while the emphasis on political determinants of health is thin at best. Past performance can oft be used as a predictor for future political decisions. Politicians, the electorate and healthcare professionals stand to benefit from such analysis as it improves decision making for policy delivery, election outcomes and healthcare distribution. By expanding the research relating to the political determinants of health our understanding stands to improve. When thinking of health, who is in government and how the health policies might change because of the ideologies associated with that party in power is exceptionally pertinent. The motivation of this research for the health field is to uncover what populist radical right (PRR) parties do when they are in government with regards to health policy. The motivation for the political science realm is to uncover whether parties actually matter, specifically in areas (such as health) that lay far from their programmatic focus.

Populist Radical Right (PRR) parties are a relevant force in Western Europe as they enter governmental coalitions thereby having the ability to change policies; of which health policies, have escaped the keen eye of researchers. Being able to anticipate what these parties will do is fundamental not only to health and political science research, but also to countries' on the verge of elections. This dissertation uses an in-depth case study approach to understand what the PRR in Austrian and Italian national and subnational governments actually accomplish with respect to health policies over time. Manifesto research is of little interest in this case, because the focus is on implementation, not promises.

Seeing as there is generally very little crossover between political science and health research, this research will add to the small literature available in the hopes of advancing the understanding of how PRR parties impact the development of a countries health systems thereby increasing the predictability of future policies and outcomes as well as generally inspiring more thought and action in this area. Who is in government matters immensely as the health policies parties implement, cut or change have serious consequences for the health of entire nations, especially given the current COVID-19 pandemic.

This dissertation argues that, when in government with a conservative coalition partner, PRR parties impact health in four distinct ways: 1) they implement welfare chauvinist policies implying that health policies for natives are expanded while those for non-natives are decreased. 2) they implement neoliberal policies. This suggests that they decrease the generosity of health policies across the board, but specifically for the non-native population. 3) They implement Conservative health policies. This would involve decreasing health sending and investment for all. 4) Finally, PRR parties in government tend to be anti-scientific in their decision making thereby going against expert opinions.

This research finds that on a national level all four of the above-mentioned arguments are valid, although dependent on the cooperation of the coalition partner, while on a subnational level, the impact is very country specific. In Austria, healthcare at a subnational level was of an area controlled by the Social Democrats and therefore difficult to influence. In Italy, on the other hand, the impact the PRR had on healthcare depended very much on the culture, geography and history of the region.

Chapter 1 **: Getting Acquainted with the PRR**

Populist radical right (PRR) parties have become an increasingly relevant force within the Western European electoral system over the past 30 years. They have entered governmental coalitions both nationally and sub-nationally and have more than tripled their share of seats in Parliament (Inglehart and Norris, 2016). The implication for this is that PRR parties have the power to make changes to national and sub-national policies, some of which – most noticeably health – have escaped the keen eye of researchers. Health, and in the broader sense, social policies, are integral parts of the welfare state whose importance lies in the ability to protect and promote the social and economic well-being of its people. It is therefore necessary to determine what PRR parties do with regards to health policies in countries where they are and have been directly involved in the decision-making process. Prime examples of relevant health and social policies are smoking bans, vaccination laws, minimum income laws and any policies excluding certain groups from obtaining welfare benefits, of which healthcare is a direct benefit.

Noteworthy PRR parties include the French Rassemblement National (RN), the United Kingdom Independence Party (UKIP) and British National Party (BNP), the German Alternative for Germany (AfD), the Austrian Freedom Party (FPÖ), the Italian League (Lega), the Hungarian Jobbik, the Polish Law and Justice party (PiS), the Finns Party, the Danish People's Party (DFP), the Vlaams Belang in Flanders, The Swiss People's Party (SVP) and the Dutch Freedom Party (PVV). These parties have dense enough international contacts to show that they view

themselves as a coherent party, though others, such as Hungary's Fidesz party are PPR parties that formally belong to and benefit from belonging to other party families.

These parties clearly do not have a monopoly on PRR rhetoric, policies, or style. Boris Johnson, Donald Trump and Jair Bolsonaro are particularly high-profile PRR leaders whose parties are not historically PRR parties. For this dissertation, however, I will only be looking at PRR parties from countries that have proportional representation systems. The incentive in a majoritarian system is to take over a major party (as with Trump and Johnson). Along with the limitation that I am looking at only PRR parties from countries with proportional representation, I have ensured that multiparty coalition politics will heavily influence what happens.

While there is an increasing list of PRR parties, only some of these have actually ever entered into government. Since the mid-90s PRR parties from seven[1] Western European countries have entered into a steady stream of national government coalitions (Akkerman et al., 2016) (Figure 1) most generally at the expense of center parties (Inglehart and Norris, 2016). Of these seven countries, at least two (Italy and Austria) have additionally seen PRR governmental coalitions form on sub-national levels. I will use four subnational level cases (Carinthia and Burgenland in Austria and Lombardy and Veneto in Italy) to leverage my national cases (Austria and Italy. Not only is going subnational innovative as there is a gap in PRR subnational research but, as mentioned, it will provide leverage.

Populism is a "thin centered ideology" (Mudde and Kaltwasser, 2017, p 6) or a political style that appeals to the common people and denounces the elites. Because of its thin-centered nature, populism is always attached to other, more thick-centered ideologies (nationalism,

[1] Austria, Denmark, Finland, Italy, the Netherlands, Norway and Switzerland.

neoliberalism, socialism), implying that populism can take various different shapes. Although always conditional on the core concepts of populism (the people, the elites and the general will), these shapes can appeal to a variety of societies. There are two common types of populism: the left and the right. Left wing populists parties tend to "combine a democratic socialist ideology with a strong populist discourse presenting themselves as the voice of the people" (Mudde, 2004). While there are some strong left populists, most notably, the Five Star movement in Italy, Podemos in Spain and Syriza in Greece, there is little disagreement that the stronger force is on the right (Greer and Falkenbach, 2018). Characterized by a core ideology of nativism, authoritarianism and populism (Mudde 2007: chapter 1), these parties are much more prevalent across Europe (Mudde, 2007) (see Figure 1 below).

When thinking about PRR parties in government, it is clear that attempts to tighten migration (Bergmann et al., 2021; Paxton, 2020) and integration (Bolin et al., 2014; van Ostaijen and Scholten, 2014) policies will be made, however it is often difficult to determine how these parties will act and what they will pursue in terms of health policies once they enter national or subnational governments.

Figure 1 PRR parties in Western European governments

COUNTRY	RRPP	PERIOD	COALITION PARTNER
Austria	FPÖ	2000 - 2005	ÖVP
	BZÖ	2005 -2006	ÖVP
	FPÖ	2017 - 2019	ÖVP
Denmark	DFP	2001 - 2005	V, KF
	DFP	2005 - 2007	V, KF
	DFP	2007 - 2011	V, KF
Finnland	True Finns	2015 - 2017	Centre, National Coalition, Blue Reform
Greece	LAOS	2011 - 2012	ND, PASOK
Italy	LN	1994 - 1996	FI, CCD-UDC, AN
	LN	2001 - 2005	FI, AN
	LN	2008 - 2011	PdL
	LN	2018 - 2019	5 Star Movement
Netherlands	PVV	2002 - 2003	CDA, VVD
	PVV	2010 - 2012	CDA, VVD
Switzerland	SVP	since 2000	CVP, FDP, SP

Source: Authors own, adapted from (Mudde, 2013a).

Past performance can oft be used as a predictor for future political decisions (Lebas and Euske, 2002). Politicians, the electorate and healthcare professionals' benefit from such analysis as it will improve decision making for policy delivery, election outcomes and healthcare distribution. By expanding on the research relating to the political determinants of health as well as the social and welfare politics as they relate to health policy, outcome prediction will improve. When thinking of health and social policies, who is in government and how the health and social policies might change because of the ideologies associated with the party in power is exceptionally relevant. Being able to anticipate what these parties will do is fundamental not only to health and political science research, but also to countries on the verge of elections.

In his 1984 book Do Parties Make a Difference?, political scientist Richard Rose, came to the conclusion that in Great Britain forces outside the control of parties (public opinion, societal changes and economic trends) impacted policies (Rose, 1984). This finding was re-evaluated in a

more recent literature review (Falkenbach, Bekker and Greer, 2019) finding that political parties and their ideologies affect health in two important ways: First, and most importantly, politics shape our health systems and establish whether a country has a national health system, a social insurance system or neither (Immergut, 1992). This means that politics frames how healthcare is thought about and approached within a society (Falkenbach and Greer, 2018): Is it considered a universal right available to all or is it an industry like the banking, textile or electronic industry subjected to the market with questionable regulations? Secondly, and as a result of the first point, political traditions affect health outcomes (Navarro, 2008). In essence, politics informs public policy and thus affects health outcomes for a given population. It is known that Social Democrats tend to favor redistributive health and welfare policies, thus generally improving health outcomes, whereas Christian Democrats and conservatives are more reserved in their redistributive policies (Huber and Stephens, 2001). The Populist Radical Right (PRR) preferences are well known as studies combing through manifestos demonstrate (Alonso and Fonseca, 2012; Akkerman, 2015); however, what policies they actually implement and enforce (specifically in the realm of health) remain enigmatic.

There is generally very little crossover between political science and health research (Navarro, 2008) and this research will add to the small literature available in the hopes of inspiring more thought and action in this area. Who is in government matters immensely as the health and social policies parties implement, cut or change have serious consequences for the health of entire nations (Silviu, 2010). Therefore, the ultimate question that this research aims to answer is: W*hat is it the PRR parties do in government regarding health policies?*

Before diving into the literature, it is important to establish whether parties, in general, even matter when it comes to developing health policies.

Do Parties Matter?

A systematic review was conducted by Falkenbach et al. asking the question whether political parties matter to welfare and healthcare policy change? (Falkenbach et al., 2019). It was found that yes, political parties absolutely matter as they make a significant difference in transforming, retrenching and revising welfare policies and thereby also health policies. The article touched on three concluding points: 1) new theories on partisanship and welfare are necessary. These should focus on the interaction of partisanship with the structures of constitutional democracies including mandates (Esping-Andersen, 1990), the presence or absence of a major party, powerful unions, former union members (i.e. the 'yellow vests' in France), social partnerships and civil society on partisanship and politics as a whole. 2) The literature shows a significant gap in research on the relationship between partisanship and health and healthcare policies as a part of the welfare system. Given the changes in parties, the creation of new parties and particularly the increased influence of the PRR parties, it is necessary to know what these parties are doing in governments and especially how they are affecting the eligibility and accessibility of health and social policies in general. 3) As Social Democratic parties continue to lose support and power across OECD countries, the question of whether they will be able to revive themselves or who will replace them as proponents of welfare expansion (Beland and Oloomi, 2015; Scruggs and Allan, 2006) becomes increasingly relevant. It is clear from this comprehensive literature review that health policies, as a separate entity of the welfare system, are grossly understudied.

The Populist Radical Right (PRR)

The literature exploring the phenomenon of the PRR in government largely focuses on how the PRR attained their support, very little is said about what they actually do when given a position of power and even less information can be found when looking specifically at what they do in terms of health.

PRR parties:

> *share a core ideology that includes (at least) a combination of nativism, authoritarianism and populism* (Mudde, 2007: chapter 1). *By nativism, I mean a xenophobic form of nationalism in which a mono-cultural nation-state is the ideal and all non-natives (i.e., aliens) are perceived as a threat to the nation. Authoritarianism entails a strict belief in order and its stringent enforcement within society through discipline, law and order-based policies. Finally, populism is defined as a thin ideology that considers society to be essentially divided between two antagonistic and homogeneous groups, the pure people and the corrupt elite, and wants politics to reflect the general will of the people* (Mudde, 2014).

Given this fact, it is less than surprising that unemployment and resentment, leading to xenophobia were common areas of research. In the mid to late 90s[2], for example, countries that were seen to have fairly low levels of unemployment (Austria, Switzerland, Italy, etc.) found themselves faced with the onset of globalization and thereby labor shortages. This stark realization led to the demand by industry to open the borders so that Eastern laborers could fill positions. This influx of new workers from different socio economic and cultural backgrounds led to the emergence of exclusionary populism (Betz, 2001; Griffin, 1999). In the words of Roger Griffen, there were many people in these countries who felt "threatened by the pace of change" (Griffin, 1999, pg. 14). The PRR parties capitalized on this fear, which fit perfectly into their existing rhetoric.

[2] For PRR party history predating the 1990s see (Mudde, 2013b).

This populist rhetoric developed not only into a general fear of what is different, but also a genuine resentment. This fear stems from loss of employment as a result of technological advancement. Researchers found that fearful or anxious citizens were more likely to acknowledge and be interested in political campaigns (Steenbergen and Ellis, 2006), making them easier targets for persuasion (Nai, 2018; Nai et al., 2017). This is exactly the psychological approach used by populists. Populist communication pits the people against the out of touch elites wherein they highlight both real and symbolic threats to society. Many of these threats surround the fear of unemployment, loss of economic prosperity or loss of cultural identity (Mols and Jetten, 2016). According to research in the realm of psychology, when fear is framed in terms of out-group issues, feelings of impending threats to in-groups increases (Huddy et al., 2005). The result is increased solidarity amongst in-group members and the rejection of the out-group (Bettencourt et al., 2001). Fear, in turn, transforms into the resentment of these out-groups resulting in a hatred towards perceived enemies (immigrants, elites, refugees, etc.) (Salmela and Von Scheve, 2017).

The Austrian case is perhaps the best case of diffuse resentment to appear in Europe (Betz, 2001). The then leader of Austria's FPÖ, Jörg Haider, launched a movement criticizing the Austrians political correctness with a campaign slogan "He says what you think" (Betz, 2002). By freeing the country of past burdens through open discourse and pardon, Haider found support in the older generation as well as from the youths that were tired of being reminded of their country's history (Betz, 2001). His strategy was using the media to fuel resentment against political correctness. This case exemplifies research in this area, with further cases to be seen in the United States, Switzerland, France etc. (Betz, 2001, 2004; Inglehart and Norris, 2016).

Immigration as a driving force of the radical right allure and success has been thoroughly researched. In fact, a recent study by E. Grande et al. shows that higher levels of politicization regarding immigration in the electoral arena can be attributed to the issue entrepreneurship of radical right populist challenger parties (Grande et al., 2019). Furthermore, a study by Podobnik et al. found that the radical right vote in a given country depends on the prevalence of immigrants in that country's population (2016). Other researchers have elaborated on the allure of populist rhetoric using the common anti-immigration stance as a way to solidify the working class votes (Albertazzi and McDonnell, 2015; Golder, 2016; Greven, 2016; Ivarsflaten, 2008). An interesting development that has occurred over the last years with regards to the PRR and the issue of immigration is that many of the mainstream parties in Western Europe are "moving in the same direction as their more radical counterparts and have— to varying degrees—adopted similar approaches to immigration and integration as well (but not necessarily using the same rhetoric)" (Odmalm and Rydgren, 2019). With this development comes the natural risk that mainstream parties are fueling radical right party support through their adaptation of more restrictive immigration positions (Down and Han, 2019).

Along with fear and resentment, according to (Grzymala-Busse, 2017), the rise of the PRR, and populism in general, can be divided into the four different causes: 1) Economic hardships, 2) International aspects such as increased support from Russia and bilateral coordination between populists, 3) The failure of mainstream parties, and finally, 4) Immigration posed both as a source of labor competition and a strain on the welfare system as well as a cultural threat.

Efforts have been made to explore PRR parties, their appeal and why they are currently represented in many Western European countries parliaments (Röth et al., 2017). The most

obvious reason, perhaps, is the linking of PRR with economics. Samir Gandesha (2018) focuses on neo-liberal globalization as a potential reason for the rise of populism. In his article on Understanding Right and Left Populism, he uses David Harvey's (2007) explanation of neoliberalism: 1) accumulation by dispossession; 2) deregulation; 3) privatization; and 4) an upward redistribution of wealth, to show that globalization has led to an increase of both economic insecurity and cultural anxiety. Three crucial reasons for these increases in fear are: the creation of surplus peoples, rising global inequality, and threats to identity (Gandesha, 2018). It is inherent that with increased globalization, certain jobs become superfluous. The argument therefore is that over time, with the growing number of people, jobs will decrease as they will become more and more automated (Shammas, 2019). This will imply that the lowest skilled workers, which consist of the majority of workers (Leigh, 2015), will not have jobs. This brings me to the second risk, namely that globalization leads to increased inequality (Berger, 2014), especially amongst low and middle income countries. This inequality is especially pronounced with regard to wages. Surprisingly, in a 2008 study on globalization and its impact on inequalities, researchers found that the "economic dimension of globalization has exacerbated industrial wage inequality in developed countries" (Dreher and Gaston, 2008, p 20) as opposed to low and middle income countries. This makes sense considering the appeal to PRR parties is predominately focused in developed, high income countries. The final risk that fuels PRR appeal is the fear of being left behind and the fear of increased diversity all of which poses a threat to identity (Hogan and Haltinner, 2015).

What links these three fears in the PRR ideology is that they can all be pinned on immigrants. PRR parties and leaders have successfully used immigrants as a scapegoats to provide answers to the "globalization losers" (Teney et al., 2014). The PRR implement a rhetoric

that appeals to the minds of the impacted "Jobs are lost because too many immigrants are entering 'our' country", "we are losing our jobs to China or India" or "immigrants are changing your culture, your language, your traditions".

In Italy for example, the Lega Nord (Northern League)[3], as the party's name would lead one to assume, previously garnered much support by using the South as a scapegoat. The LN appealed to northern voters because of their consistent criticism that the South was lazy and the North had to transfer their hard-earned resources to the South (Betz, 2001; Savelli, 1992). Today, the populist party under Matteo Salvini is simply known as Lega and choses to blame the European Union, specifically the "Euro" for much of the country's financial troubles (Albertazzi et al., 2018). When a countries economy is not doing well, the citizens of a country want a reason and the far right can usually supply this in various forms: unemployment rates, resource distribution, and the EU's influence over national politics and decision making (Grzymala-Busse, 2017).

The international aspects supporting the rise of the PRR, can generally be traced to Putin and his efforts to weaken the European Union as well as the tie between Europe and the United States allowing for an increase in his own power and importance (Grzymala-Busse, 2017). There is no question that Russia is involving itself more and more with Western countries domestic policies. For example, Putin helped finance LePen's radical right party Front National in 2017 (Klapsis, 2015; Oliker, 2017; Shekhovtsov, 2017), signed cooperation agreements with the Austrian FPÖ in 2016 and of course the involvement in the 2016 US presidential election

[3] The Lega Nord had been known as a regionalist populist party until Matteo Salvini took over the lead in 2013. Now, 2018, the regionalist ideology has been replaced by an "empty form of nativist nationalism" (Albertazzi, Giovannini, and Seddone 2018, pg 645) and the party is simply known as Lega.

(Oliker, 2017). In addition to Russia's support for the PRR, there are also strong coalitions being formed between PRR parties, most notably the Hungarian Fidesz and the Polands PiS. Fidesz and PiS have united in the "defense of Europe against the madness of the left" and have supported one another when the EU has criticized them for their politics (Grzymala-Busse, 2017).

The third point, the failure of mainstream parties to contain the threat of the PRR, is perhaps what matters most; especially in countries like Poland and Hungary where both PRR parties govern without constraints and have no coalition partners or any other checks and balances. Centrist parties have been governing for most of the 20th century, however where these parties are weak, fail to articulate a clear vision and most importantly neglect to address the fears of the people, PRR parties arise. Particularly in Western Europe, the rise of the PRR "is a reaction to the failure of traditional parties' ability to respond adequately in the eyes of the electorate" to issues surrounding mass migration and financial insecurity (Albertazzi and McDonnell, 2015; Albertazzi and Mueller, 2013). PRR parties have, in part, found support because democratic politics have, in many ways, lost the ability to clearly address the frustrations of the people (Grzymala-Busse, 2017).

It therefore comes as no surprise that there has been an attempt to understand the PRR's inherent dissatisfaction and adversity towards traditional political parties. Here, research has found that suspicion toward the party system as well as a country's elites has initiated much support from young, educated middle classes, which the populist right has effortlessly capitalized on (Betz, 2001; Kitschelt & McGann, 1995). In his comparative analysis of the radical right in Western Europe, Herbert Kitschelt argues that the populist appeal derives from their strong opposition to systems that have dominated for decades (Kitschelt & McGann, 1995). Prominent

examples of this practice come from Austria, Italy and Switzerland where PRR parties (Austria's FPÖ, Italy's Lega and Switzerland's Peoples Party SVP) adopted a strategy of rejecting and criticizing not only their colleagues on the left, but also those in the center right stating that they were abandoning their national and bourgeois roots (Betz, 2001; Diamanti, 1996; Graf, 1996; Leuzinger, 2017).

Finally, immigration as a threat to a society's culture and its workforce is clearly an important issue to PRR parties. However, PRR parties do not see immigration as their most important issue, rather these parties "link their ideological core of xenophobic nationalism to the increasing 'uneasiness' and even resentment among parts of the electorate" thereby using the immigration as a catalyst for electoral success (Mudde, 1999, p 192). What this implies, according to Mudde, is that immigration is not the PRR's only catalyst issue, however it is one that has, over the years, reoccurred. Its most recent reoccurrence was during the 2015 migration crisis in Europe.

Despite all the research surrounding the rise of the PRR and the policies they proclaim to follow, there remains a gap in the literature when thinking about how these PRR parties act once they enter government. Two relevant Oxford handbooks have been published on populism (Kaltwasser et al. 2017; Rydgren 2018) with 68 chapters between them. *One* is about impact. Although it is important to know why and how PRR parties come about, we are currently in a situation where it is arguably more important to be able to understand what they do when they hold governmental positions and the policies they implement in that position.

The PRR in Government

With sufficient literature covering the rise of PRR parties and their appeal to Western Europeans, researchers began focusing on concrete action points and policies that PRR parties in governing coalitions actually implemented.

As could be predicted, the scholarly focus was predominately on immigration and migration policies as these were considered the PRR domain (Akkerman, 2012; Ivarsflaten, 2008; Mudde, 2007) and one of the main reasons the parties were elected in the first place (Van Der Brug et al., 2000). The main findings in this literature can be summarized as:

1) Anti-immigration policies are intensively promoted and supported (Akkerman, 2012; Bale, 2008; Bale et al., 2010; Jungar and Jupskås, 2014; Mudde, 2010; Spanje, 2010; Zaslove, 2008). Timely examples of this are Chancellor Kurz' vehement opposition to the involvement of European countries in the rescue of migrants in the Mediterranean stating that "Because of the sea rescue more people had made their way [to Europe] and refugee smugglers have earned more, and this had resulted in more deaths. You have to destroy the smuggler business model instead of supporting it" (Hermann, 2020). Former Italian Minister of interior, Mateo Salvini from the PPR party "Lega", also pledged to begin deporting illegal migrants (Curz, 2017).

2) There are increased restrictions in integration policies (Akkerman, 2012; Akkerman and De Lange, 2012; Bale, 2008; Luther, 2011; Lutz, n.d.; Zaslove, 2004). The most current example can be taken from Austria where the ÖVP/FPÖ government (Kurz I, 2017-2019) decided to reduce benefits to Hungarians, Poles, Romanians and Slovaks working in Austria if their children lived in their home country (Bild.de, 2019). This model is still in effect today even though the FPÖ is no longer in government.

3) When PRR parties are successful and anti-immigration policies become salient, all other parties, particularly the more center right parties are incentivized to take up a more

restrictive position on immigration (Bale, 2008; Bale et al., 2010; Spanje, 2010). We can see this example in both Austria and Italy with both coalition partners the Austrian Peoples' Party (ÖVP) and the 5 Star Movement in Italy tightening their positions on immigration and migration to follow suit with their radical right partners. Again, we can look to Austria for an example where the ÖVP and Green party coalition (Kurz II, 2000 - Present) have agreed that "In the case of asylum, the systematic deportation of third-country nationals whose protection status has been revoked will continue and the headscarf ban that currently applies in kindergartens and primary schools will be extended to young people up to 14 years of age" (Focus, 2020).

4) Most importantly, many of the policies that the PRR would like to implement in regards to anti-immigration, integration restrictions, etc. are deemed unconstitutional by the national or European Court of Justice or are not supported by the coalition members (Afonso, 2014; Albertazzi and Mueller, 2013; Heinisch, 2003b; Zaslove, 2012). In 2002, for example, the Austrian minister of interior attempted to pass a directive withdrawing state support from all asylum seekers except Afghanis and Iraqis, which was considered a breach of human rights by the Austrian High court and withdrawn (Albertazzi and Mueller, 2013). The reduction of benefits to the children of foreign nationals working in Austria mentioned in point 2 has also been deemed unconstitutional by the European Court of Justice, but this was simply ignored by the previous ÖVP/FPÖ government in 2019. Former Minister of Family Affairs, Juliane Bogner-Strauß (ÖVP), stated: "We [will] continue to assume that the solution we have chosen is compatible with European law" (Bild.de, 2019).

While these political areas are of importance, they do not give a holistic view of the PRRs impact on policies when in government and they do not show how or if the welfare system changes under PRR rule.

The social policies that the PRR parties have implemented or supported have generally been excluded from research up until 2017, and even then, the research is thin at best. Previous research (Afonso 2014; Bale 2003; Ennser-Jedenastik 2016; Rooduijn, de Lange, and van der Brug 2014; van Spanje 2010; Williams 2006) on the social policy impact of PRR in government can generally be summarized as nonexistent (Muis and Immerzeel, 2017) with a few exceptions.

In his analysis of pension reforms during the PRR participation in the Austrian, Dutch and Swiss governments, Afonso (2014) finds that although these parties claim to support social benefits, when they find themselves in office however, these promises become difficult to follow through on. Welfare and health policies prove to be rather unsafe areas for PRR parties when in government as they are faced with a "tradeoff between office and votes" (Afonso 2014, pg 18).

Bale (2003) chose to focus on the restrictions that arose for PRR parties in government due to their center right coalition partner. Particularly in economic policies, the center right refused to back more interventionalist and nationalistic economic policies and instead put forth more market liberal policies (Bale, 2003). He hints on a similar trend for social policies but fails to elaborate and moves onto immigration policies.

The social policy profile of the PRR party in Austria is analyzed by Ennser-Jedenastik (2016) coming to the conclusion that the FPÖ follows a welfare chauvinist approach in their welfare policies demanding generous benefits for citizens while limiting access to foreigners (Ennser-Jedenastik, 2016).

The research on PRR polices conducted by Rooduijn et al (2014) combs through party manifestos and concludes that PRR parties change their programs once achieving electoral success and adapt their policies more towards the ones followed by their coalition partner (Rooduijn et al., 2014).

In her chapter on PRR impact, Williams (2006) never strayed far from the theme of immigration as the main source of all social an economic concerns within a given country and summed up her chapter with the identification of the European Parliament as an important source of PRR influence as well as the general inclusivity of institutional effects on the PRR (Williams 2006).

Judging from these results it is unclear whether PRR parties in government simply had a limited impact on social policies or whether the research was focusing more on immigration and migration policies because they were timelier subjects to study. After 2017, there are a few articles (Ennser-Jedenastik, 2018; Scott L. Greer, 2017; Röth et al., 2018) that push the envelope a bit further on the topic of PRR parties and social policies however none of them touch specifically on health policy, other than (Falkenbach & Greer, 2018). This latter article asserts that PRR parties in government de-emphasize the issue of health or social policies preferring to turn the focus instead on immigration and migration. The article postulates that these parties tend to pursue exclusionary policies, and that it is unclear whether these policies increase or decrease benefits for the "native" population. The authors are, however, unable to specify what policies the PRR tend to follow and if their policies are actually beneficial to their voter base (Falkenbach & Greer, 2018).

In his 2017 article on Medicine, public health and the PRR, Greer asserts that the populist radical right is a "threat to [the] core values of medicine and public health even when they hold office in a functioning democratic system", but fails to elaborate on this point (Scott L. Greer, 2017). Röth et al. performed the first mixed-methods comparative study on the PRR socio-economic impact finding that "these parties not only refrain from welfare state retrenchment but are also less inclined to engage in deregulation compared with right-wing governments without

PRR participation." In addition, they state that PRR parties find it "easier to liberalize in domains that are not very salient or technical (such as economic regulation) than in ones that are highly politicized (such as welfare issues)" (Röth et al., 2018). Ennser-Jedenastik adds to the theoretical literature on the PRR and welfare chauvinism (discussed in detail in Chapter 2) in that he finds "social insurance systems [to] be more resilient in the face of welfare chauvinistic rhetoric than universal or means tested benefits as they award benefits based on an individual's contribution and they cut [them] against the impulse of pitting the native in-group against the non-native out-group" (Ennser-Jedenastik, 2018).

Summary of Finings

The goal of this dissertation was to assess how PRR parties in government impact health policies across two countries and four subnational regions within those countries. This dissertation found that elements of welfare chauvinism, increasing benefits for the native population while simultaneously decreasing them for the outgroup, were common within the health policies passed by the PRR in government. The effectiveness of these policies depended on two fundamental variables: 1) the coalition partners willingness to agree to such policies and 2) the strength of the institutional courts within the country.

The willingness of the coalition partner generally depends on tow aspects: their strength and their political orientation. This implies that the coalition partner is typically stronger than the PRR party, which often makes it difficult for the PRR party to implement its desired policies. In most cases, however, PRR parties form coalitions with a stronger center right party. With such a constellation, the PRR party often finds support for their proposed health policies.

The second approach that PRR parties in government were found to take is the liberal chauvinist one. Policies following this approach typically decrease benefits for all with the strongest impact on outgroups. While the PRR's welfare chauvinist policies were often hindered by constitutional rulings as well as by an unwilling coalition partner, liberal chauvinist policies were generally supported by the coalition partner (if of conservative orientation) and rarely ever questioned by the courts. As previously mentioned, Conservative, or center right parties, most often form coalitions with the PRR. In such cases liberal chauvinist policies, also within the realm of health, are not uncommon as they serve the interest of both political parties: a decrease in spending (conservatives) while also making life more difficult for outgroups (PRR).

Countries like Austria, where health policies are primarily made on the national level, will find that the PRR can have a greater impact when they hold positions in the national government. On the other hand, countries like Italy, where healthcare has devolved to the regions, it makes more sense to look at PRR health impact on a regional level.

Conclusion

There was a great deal of research on populist parties and their voters, but very little on their effects on policy, and what was there, was often more of a hypothetical or an assertion in an editorial. Amazingly, at the intersection of two of the biggest bodies of literature today, we find very little. We do not know what populists do to health or health policy when they are in government.

It is evident that research surrounding the impact of PRR parties on health policies is slim, therefore the task this book has set out for itself is to not only add and expand on the

existing literature, but to also contribute relevant data so that governmental coalitions with the PRR and their impact on health may be better understood across Western European countries.

The remainder of the book follows the following outline. In Chapter 2, I examine the literature related to the welfare state, welfare chauvinism and partisanship. In this chapter, I argue that the PRR parties follow one of two strategies with regards to welfare politics. They either follow a welfare chauvinistic, restricting benefits to the native population and excluding immigrants, path or push towards a neoliberalistic, a general reduction of benefits to all, one. In Chapter 3, I highlight the methods used for this research project. To understand what health and social policies PRR parties follow when in government, I conducted in-depth comparative case studies across two countries and five regions. Selection is of utmost importance for case studies. For the national studies, the cases of Austria and Italy were most relevant as they are the countries that have had PRR parties in government over the longest period of time.[4] The cases selected for study were Austria and Italy on the national level and the provinces of Burgenland and Kärnten (both in Austria) as well as the regions of Lombardy and Veneto (both in Italy) on the subnational level. In order to understand variations in policies across the cases, I collected two types of data. First, I conducted semi-structured key informant interviews across each of the case study states, employing stratified sampling and chain sampling methods within each country and region. Second, I collected and analyzed documents, including written and oral legislative testimonies, legal material, and governmental reports related to the policies and politics of PRR parties.

[4] The SVP in Switzerland have of course been in government the longest but due to the difficulty in comparing Swiss politics to other Western European countries, this case option was excluded.

In chapters 4 and 5, I individually analyze both national cases. Beginning first with Austria in chapter 4 and then moving to the national case of Italy in chapter 5. In chapters 6 and 7 I move to the subnational level in both countries. Chapter 6 looks at the provinces of Carinthia and Burgenland, while chapter 7 explores the regions of Lombardy and Veneto. In Chapter 8, I use the COVID-19 pandemic to look more deeply at the PRR actions within my cases. Although the FPÖ was and is not in power during the pandemic, I look to how they react to COVID-19 as a party in opposition. The interesting exploration occurs on a subnational level in Italy where the Lega were and are still in government making these exceptionally interesting cases to explore in the midst of a world-wide pandemic to see how PRR parties impact health. In chapter 9, I provide an overview of the key themes that emerged collectively across the cases and explore how the findings can be applied to other countries and their PRR parties.

Chapter 2 **: Welfare Chauvinism vs. Welfare Austerity**

Most European states enjoy a well-entrenched welfare system that has always had the purpose of serving as a safety net for the people. Health and social policies fall nicely into the category of the welfare system, however, health alone, as an important entity of the European welfare model, has not yet been considered within previous research on this topic. As established in the previous chapter, political parties do, in fact, impact health policies; however, in order to properly study these policies, it is helpful to determine what type of welfare politics are being implemented in a given country.

This chapter will progress where chapter 1 left off. It will continue to convince the reader that further investigation into the health policies passed by parties in government are necessary not only within political science research, but also within public health research. This chapter will begin by looking at the welfare state theory in order to prove that, as touched on in chapter 1, parties' matter when thinking about policies. Then, the chapter will focus on how a specific party, the PRR, approaches welfare policies.

Backing up just a bit, some definitional work is necessary before we continue talking about the existing welfare theories. First of all, a political party, as I will use the term throughout this dissertation, is "any political group that presents at elections, and is capable of placing through elections, candidates in public office" (Sartori, 1976). Parties serve crucial functions as they coordinate politicians within legislatures and between different (e.g. local and central) governments, structure political careers and recruitment, create networks of diffuse reciprocity between politicians over time and provide labels voters can understand (Aldrich, 1995).

Collectively, parties form party systems. This is simply the sum of parties and their relationships to one another, typically mapped in some sort of ideological space (e.g., left-right). Parties in Europe, and the world, form families based on their shared predispositions, such as Social Democratic, Liberal, Christian Democratic or the Populist Radical Right, and they often coordinate their actions across borders. An individual's preference for the victory of one party over another is known as partisanship. In other words, partisanship implies party identification and is the result of affective attachment due to socialization (Campbell et al., 1980; Settle et al., 2009) that stems from childhood and reflects ones familiar surroundings (Hyman, 1959).

Several theories surrounding the welfare debate help us understand how political parties, political systems and partisanship can relate to the welfare state. This is important because it motivates how political parties think about the welfare state and ultimately what kinds of welfare policies parties in government pass.

Part I: Welfare State Theory

There are two dominate theories in the partisanship debate that have always been accepted and used in the literature to explain how partisanship influences the direction of a government as it relates specifically to welfare policies. The first is the Power Resource Theory also known as the "old politics perspective" (Giger and Nelson, 2011). This theory posits that partisanship matters greatly, especially in an era of austerity and retrenchment. The general notion assumes that parties of the Right retrench more than those of the Left and parties of the Left and unions are associated with welfare state expansion (Allan and Scruggs, 2004; Korpi, 1983; Korpi and Palme, 2003). The perspective is supported by Walter Korpi and colleagues and states that by mobilizing the citizens from the lower socio-economic ranks the social democratic parties and

their allies are able to be electorally successful, which in turn is vital for the survival of the welfare state (Korpi, 2003; Korpi and Palme, 2003). It holds that Left wing parties are generally in support of welfare expansion because they represent working class interests (Häusermann et al., 2013) and the generosity of welfare will vary with the strength of the Left wing party. In addition, many supporters of this perspective support the notion that welfare politics can still be considered the same democratic class struggle it was over 50 years ago (Häusermann et al., 2013). Essentially, the PRT explains that the success of social democratic parties began to decrease because working class power resources diminished (Gingrich and Häusermann, 2015). This in turn gave rise to a social democratic party whose core voting base was made up of civil servants. The bottom line: partisanship matters.

The Christian Democratic dimension of the Power Resource Theory highlights the contrasting effects of Christian Democracy and Social Democracy on social benefit expenditures (Esping-Andersen, 1990a; Huber et al., 1993), among others. This dimension finds that Christian Democrats also strive to expand the welfare state, however in a much less egalitarian (Levy, 2001) way compared with the Social Democrats (Huber et al., 1993). Again, the bottom line: partisanship matters.

The second dominate theory of the welfare state is the New Politics Approach. This approach considers the governmental budget problem through the lens of demographic changes such as population aging and pension costs, decreasing economic growth rates and a general increase in social expenditures. The New Politics Approach was promoted most strongly by Paul Pierson who consistently argues that because we live in an 'era of austerity' partisan differences have little influence on the direction and scope of welfare state reform and thus welfare and social policy (Pierson, 1995, 1996, 1998). When looking solely at social policy, this perspective

posits that it is difficult for parties of any color to support a policy of retrenchment because of the popularity of the welfare state (Albertazzi and Mcdonnell, 2008). This same conclusion is drawn when looking particularly at healthcare: The partisan character of government no longer plays a significant role in determining changes in public responsibility. The bottom line: particularly in periods of retrenchment and austerity, partisanship ceases to matter.

The disagreement between the two approaches can be found in how they view the role of partisanship as it pertains to welfare generosity. As previously mentioned, the Power Resource Theory believes that partisanship matters despite austerity measures wherein the Left is more likely to expand welfare generosity and the right is more likely to retrench. The opposing view of the New Politics approach proclaims that partisanship in an era of austerity no longer matters because neither the Left or the Right will dare cut welfare benefits for fear of losing the support of their constituencies. Other theories exist as well, but they are marginal and not widely represented within the literature. Market liberalism supports the notion that market liberal parties find it easier to retrench welfare policies because voters themselves have moved into a more libertarian policy space (Kitschelt and McGann, 1995) while the contingency theory, Nixon Goes to China, posits that voters trust parties that were historically pro welfare state and are more likely to forgive these parties should they retrench (Giger and Nelson, 2011).

Much of the literature in the review conducted by Falkenbach et. al., finds that the Power Resource Theory seems to fit with results from 1945 to the mid-1970s (Falkenbach et al., 2019), while some researchers argue its relevance until the 1980s (Kittel and Obinger, 2003). The years between 1945 and 1970 were known as the "golden age of the welfare state" (Wincott, 2013) where there were considerable distinctions between Left and Right leaning regimes (Esping-Andersen, 1990a; Huber et al., 1993). The Left expanded welfare generosity whereas the Right

chose to, more often than not, keep the status quo. This was mostly due to an increase in economic globalization as well as centrally organized labor and strong labor movements (Hicks and Freeman, 1992) which consequently led to a decrease in unemployment (Kwon and Pontusson, 2005). During this "golden age", the Left encouraged spending on social services which led to increased participation in the labor market, particularly among women, and stimulated strong labor movements (Levy, 2001). Right-wing governments, on the other hand, were typically associated with promoting less egalitarian welfare systems (Levy, 2001) focusing instead on the liberalization and privatization of the product markets. By the late 1970s and the early 1980s (some argue a decade later—1990s (Kittel and Obinger, 2003; Levy, 2001)) researchers began questioning the importance of partisanship as alternative explanations for welfare policy change emerged: growth was slowing, unemployment was increasing (Hicks and Freeman, 1992; Kwon and Pontusson, 2005; Scruggs and Allan, 2006), globalization was flourishing (Hicks and Freeman, 1992; Starke et al., 2008) and the population was rapidly ageing, all of which resulted in a changing welfare burden on society, which formed the basis of welfare redistribution. This initially led to slower welfare expansion. One researcher even made the claim that: "During periods of fiscal difficulty, a government with a strong funding base, regardless of its partisanship and the original intentions of policy makers, has resisted welfare retrenchment" (Kato, 2003 p. 40). It was at this time, the late 1970s to the early 1990s, that the New Politics Approach garnered support with its theory that partisanship no longer mattered, as both the Left and the Right were afraid to cut welfare benefits (Wolf et al., 2014). This perspective was then challenged by the Power Resource Theory with the argument that partisanship still mattered and continued to affect welfare outcomes in arguably conventional ways (Allan and Scruggs, 2004; Kwon and Pontusson, 2005). Allan and Scruggs, e.g. showed in

their work that since the 1980s Right-wing governments were generally associated with welfare retrenchment (Allan and Scruggs, 2004).

In essence, the theories and the literature tell the following story: after the end of the "golden age" in the mid-1970s, the economy spiraled downward (triggered by the two global oil crises in the 1970s) causing unemployment to increase. The result was fiscal stress at the same time that public expectations of social benefits and welfare in general shifted upward (Bonoli, 1997). Due to this fiscal stress that continued into the late 1980s and early 1990s, the Left was unable to continue to expand welfare while at the same time the Right was unable to cut the existing welfare benefits because there was such strong popular support for entitlements. Altogether, this decreased the partisan effect on welfare, leaving the social benefits static. In this context, partisanship matters insofar as parties on the left have shifted away from expanding and instead focus on defending social entitlements. While welfare states are not all on the same trajectory, there does seem to be a clear inflection in the 1980s and early 1990s as countries entered the politics of austerity.

When looking specifically towards healthcare policies, the findings are quite similar to the overarching conclusion: partisanship mattered until the 1980s (with the inflection varying by country), with Left parties spending more and exerting a positive effect on preventative health (Johan P. Mackenbach and McKee, 2013) while the Right resisted expansion or attempted to cut benefits (Falkenbach et al., 2019). After that point, there was no longer a difference, as neither the Left nor the Right cut or expanded health benefits and partisanship ceased to matter as a major influencer (Jensen, 2011; Jordan, 2011; Kittel and Obinger, 2003). In a study on whether political parties' matter for the implementation of specific preventative health policies, McKee and Mackenbach found that positive health effects used to be associated with Social Democrats

being in government, particularly in relation to indicators such as tobacco and alcohol control. The last decades, however, found little correlation between Social Democratic governments and health policy development (Johan P. Mackenbach and McKee, 2013). We see government coalitions no longer being made up of Social Democrats and Conservatives rooted primarily in class-based politics, but rather the conservatives or liberals governing with the Populist Radical Right (Falkenbach & Greer, 2018).

The 2015 migration crisis tapped into existing yet implicit sentiments and enabled increased social acceptance and growth of an identity-based electorate and politics on the right. This also involved a shift of Social Democratic and Left parties away from their roots in the organized working class, with their adoption of economic and welfare system reforms, climate change policies, globalization, etc. thereby disregarding traditional supporters' economic concerns.

A major determinant of variation in policy choices, including health policy and output is the party composition of government (Hibbs, 1992). Larger partisan effects can be seen in majoritarian, parliamentary, democracies where the legislature and the executive are 'sovereign'. The structure of the welfare state also matters, with social insurance and social partnerships forming a barrier to action by any government. The institutional structures relinquish some of their power particularly in matters relating to social insurance contracts. Even in countries with divided powers (federations, presidential democracies), a Right-wing government in power for a long period of time leads to lower healthcare spending (Herwartz and Theilen, 2014).

The general consensus that can be reached from the welfare literature is that the Power Resource Theory generally prevails within the literature as the Left (or liberals) will generally seek to expand the welfare state while the Right (or conservatives) will either keep it the same or

push for cuts in certain areas (Achterberg and Yerkes, 2009; Amable et al., 2006; Brady et al., 2005; Hicks and Freeman, 1992; Scruggs and Allan, 2006). As far as healthcare is concerned, very little has been researched as to what parties do with regard to health policy. A scoping review conducted in 2020 confirmed this point as it found there was little research "about the direct relationship between PRR parties and health" (Rinaldi and Bekker, 2020). In fact, they found the research surrounding health policies to be so thin that they had to expand their scope to include social policies. Generally, it is said that parties from both the Left and the Right tend to expand health care (Jensen, 2011), however we see this changing if the coalition is no longer made up of Social Democrats and conservatives, but rather the conservatives and the PRR (Falkenbach & Greer, 2018). Rinaldi and Bekker ended up combining social and health policies leading them to the conclusion that PRR parties, like other parties, impact welfare policies. The PRR impact, they found, is seen through the implementation of a welfare chauvinistic agenda that restricts access and eligibility to provisions for outsider groups such as immigrants and minorities (Rinaldi and Bekker, 2020).

Seeing as the typical partisan construct of Left and Right is no longer the only dominant governmental form and that PRR parties are beginning to take part in governmental coalitions, it is necessary to determine how PRR parties impact the welfare state and more importantly health policies.

Part II: PRR Welfare Approaches

I have now shown you that PRR parties impact policies surrounding migration, security, integration and also social policies (chapter 1). In the previous section, I have displayed how the traditional social democratic and conservative parties approach welfare policies. What is missing

from the literature of the last section is a discussion surrounding how PRR parties approach welfare policies. In this section of the chapter, the theory surrounding the PRR welfare approaches will be discussed followed by how PRR parties shape policy and ending on the limited literature that actually talks about PRR parties and their impact on welfare policies, most particularly health policies.

According to the literature, a PRR parties' social welfare policy can fall into two distinct categories: (1) PRR want to protect citizens' social welfare benefits, of which health care is a big part, from non-citizens (mostly migrants), thus embarking upon an exclusionary model known as *welfare chauvinism*[5] (Ennser-Jedenastik 2016; Mudde 2009, 2016). In recent years PRR parties have criticized mainstream parties for cutting welfare to benefit the immigrants (Schumacher & Kersbergen, 2016). This implies that they support the welfare state, but only for the native people. (2) The other possibility is that PRR engage in welfare austerity (Greer & Falkenbach, 2018), or neo liberal policies (Kitschelt, 2007), combining racial and ethnic animosity while essentially cutting welfare expenditure for all (Ivarsflaten, 2008; Oesch, 2008; Swank & Betz, 2003). However, no study has, as of yet, investigated PRR parties' effect on health policies in particular, instead welfare systems as a whole were examined (de Koster, Achterberg, & van der Waal, 2012; Facchini, Mayda, & Murard, 2016; Schumacher & Kersbergen, 2016; van der Waal, Achterberg, Houtman, de Koster, & Manevska, 2010). It is therefore unclear as to whether all PRR parties follow one or the other model, whether there are particular circumstances, i.e., Coalitions, that lead to the use of one model over the other, or whether it simply depends on the country under investigation. In order to better understand what PRR parties do in government,

[5] This term was first introduced by Andersen and Bjørklund and stated that "welfare services should be restricted to our own" (Andersen and Bjorklund, 1990).

particularly with regards to health policies, it is essential that researchers have a clear understanding of the circumstance that led to a given welfare policy.

In an effort to determine which welfare approaches PRR parties take, it must be understood that these parties get elected because they claim to support the "common man" (Betz, 1993) promising to restore their voices within the political debate (Immerzeel and Pickup, 2015). Initially, it was thought that PRR parties fill their voter base with people of lower education, the unemployed, blue collar workers and people that have a generally negative attitude towards immigrants (Lubbers et al., 2002). While it is certainly true that the unemployed, in particular, perceive immigrants as an economic threat, this type of voter base is not what makes a PRR party successful, and does not apply to all PRR parties equally[6]. What makes the party successful, thereby helping it to enter a governmental coalition, is the ability to attain votes from voters that previously voted for a different party (social democrats or conservatives) (Immerzeel and Pickup, 2015). Previously social democratic voters typically move to the PRR because of economic deprivation and job loss (Jylhä et al., 2019). Previously conservative or Christian Democratic voters on the other hand defect to the PRR because they are concerned about immigration and the European Union (Webb and Bale, 2014). PRR parties, appeal to voters for different reasons depending on the given circumstances in any one country. Sometimes they appeal to the "common man", other times they appeal to the educated self-employed. The point is that the appeal evolves over time. The common thread is that the party group manages to pit groups against one another: in vs out groups. This can range from citizens vs. immigrants

[6] In Austria and Italy, for example PRR voters are more heterogeneous (Betz, 1993). In Austria, the PRR appeals to younger, welfare state minded, above average educated white-collar workers; market oriented, above average educated, self-employed white-collar workers; and skilled, blue collar workers (Plasser et al., 1992). The Lega in Italy attracts both blue collar workers as well as the self-employed with above average levels of education (Natale, 1991).

(although this is fairly common in all PRR parties) to self-employed small business owners vs. industries and globalization and well-educated white-collar workers vs. political elites. The question that arises is how do PRR parties determine what welfare approach to take to appease their voter base, and more importantly what does that mean for health?

Several scholars have attempted to explain how PRR parties deal with welfare benefits and they have chosen to do this by distinguishing "deserving" from "undeserving" citizens (van Oorschot, 2006). Ennser-Jedenastik creates a table of those "deserving support" versus those "undeserving of support" to explain the welfare sentiments of the Austrian PRR party between 1983-2013 (Ennser-Jedenastik 2016 pg 214). In his piece on pension reforms, Afonso explains that the "deservingness" of a particularly group, for example pensioners, will save them from retrenchment (Afonso, 2014). Afonso and Papadopoulos focus on the Swiss case and argue that PRR parties eagerly use the popular ordering of deservingness accepted across Europe to determine which category of recipients are "more deserving" of benefits (Afonso and Papadopoulos, 2015b).

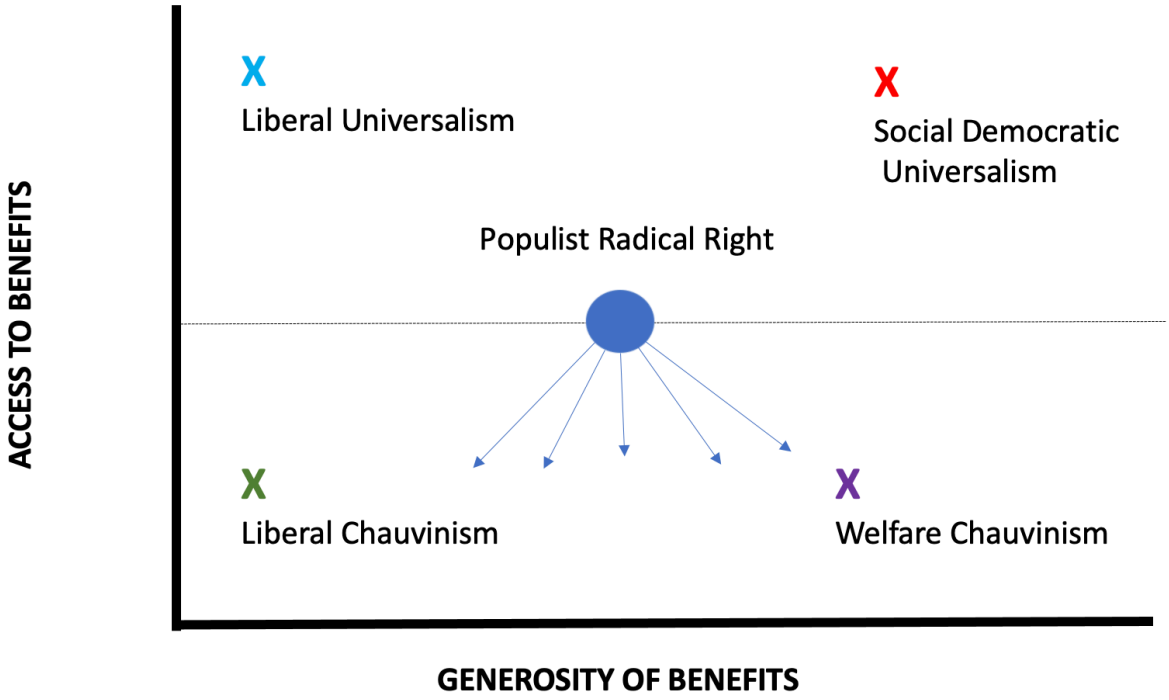
Thinking about welfare programs such as healthcare along two axes: generosity and the exclusiveness of benefits (Figure 2) proves useful. The *generosity* of benefits is a longstanding preoccupation of the welfare state literature. Conceptually, it is the extent to which a welfare state decommodifies by reducing people's dependence on money. This can, for example, be seen as the amount of social protection offered unemployed and how actively labour market policies are pursued to decrease unemployment (Van der Wel and Halvorsen, 2015). When thinking about healthcare this implies the extent to which access to healthcare is independent of income (Esping-Andersen, 1990). For health, the generosity of benefits can be and is measured in a variety of ways, e.g., out of pocket expenditures, prevalence of catastrophic health care

expenditures, financial barriers to access, or resource-based barriers to access such as the adequacy of facilities.

The *exclusiveness* of benefits is and is not a longstanding preoccupation of the welfare state literature. It is, insofar as inequalities in access and benefits within systems has long interested analysts. It is not, however, insofar as the access of outsiders such as migrants to benefits is a newer and largely separate field. Conceptually, the exclusiveness of benefits is the extent to which access to benefits is restricted on grounds of, for example, citizenship, residency, or participation in a social insurance scheme. The least exclusive benefits are available to all. The most exclusive benefits are those which require membership in some scheme that involves having money, legal residency, and an established labour market position. Healthcare examples pertaining to the established welfare states in Europe include the option of attaining private insurance on top of the mandatory social health insurance in countries like Austria. Only people that have sufficient resources, i.e., money are able to afford such a luxury that might grant them everything form shorter waiting times to the privilege of choosing which hospital and specialist will care for them. In NHS systems such as Italy, money, in the form of the ability to pay out-of-pocket for extra services, gives some people an advantage in securing more timely access to care.

In an effort to display a more visual interpretation of the above, I created a four-policy model depicting the relationship between access and generosity.

Figure 2 Four Policy Model



Source: Authors own.

In the upper left-hand corner, the liberal universal approach calls for minimal state intervention in the lives of the citizens. Libertarians, even today, support a free-market health system, which typically results in low health expenditure, translating into less generous benefits, and low exclusivity implying relatively unhindered access to benefits. Another option, found in the upper right-hand corner of the graph, could be termed Social Democratic Universalism. This scenario is currently practiced in the autonomous community of Catalonia, which has refused to implement a Spanish central state decree cutting off health care benefits to undocumented migrants (Castano et al. 2016). This system ensures that everyone has equal access to healthcare services no matter if they are a citizen or not, which amounts to both the increased access to

benefits as well as the increased generosity of those benefits. This also implies that the health expenditure is higher for cases that fall into this quadrant.

The two most probable approaches in the case of PRR parties in government can be found in the lower left- and right-hand corners, respectively. Initially, PRR parties tended to lean more towards having an economic liberal orientation, promising freer markets, lower taxes and less statism (Kitschelt and McGann 1995), which can be referred to as a combination of nationalism and neoliberalism (Kitschelt and McGann 1995; Spies and Afonso 2017) or simply, welfare austerity (Greer and Falkenbach, 2018) or liberal chauvinism. This means that there is, for example, little support for the collective financing of health care services (Greer 2017) resulting in less generous benefits. In the late 90s, most PRR parties held an extreme cultural authoritarian position, however adopted a more lassiez-faire policy approach, which in turn called for less redistribution, tax cuts and reduced welfare expenditures (Spies and Afonso 2017). Conservative parties, such as the party formerly led by Theresa May in the United Kingdom, have adopted the old radical rights neoliberal approach resulting in decreasing the amount of money spent on healthcare and thereby decreasing the generosity of benefits provided while also increasing its exclusivity implying that those benefits are harder to access.

When thinking about a liberal chauvinist approach to healthcare, PRR parties might chose to call for significant reductions in spending towards health care. A good example of such a policy comes from Hungary. Although it was not implemented, the National Budgets Act would have resulted in the significant reduction of public health care spending. The result would have been the continued underfunding of public health care facilities, increased problems with the medical infrastructure, shortages of basic equipment like soap or toilet paper, and the stagnation of health sector workers' wages (Moise et al., 2021). In the United States, the

Medicaid Block Grant, is an example of a liberal chauvinist policy passed by Donald Trump. The Block Grant waivers covers fewer people, and provides coverage that offers less financial protection and worse access to care (Singer and Willison, 2021). Both examples signify a decrease in health benefits for all, however, the decrease would most effect a specific group of people (immigrants, minorities, etc.).

Since the mid-90s, however, a trend towards "welfare chauvinism" among PRR parties was found. This approach depicted in the lower right quadrant of Figure 2 implies that benefits are more generous due to an increase in health expenditure, however, these benefits the access to these benefits are restricted making them more exclusive. Anderson and Bjorklund first used the concept of welfare chauvinism in a social science paper and described it as a notion where "welfare services should be restricted to our own" (Andersen & Bjorklund, 1990, pg. 212). The Danish People's Party, for example, was successful in demanding a change of social policies where the "length of stay principle" in effect excludes foreign born immigrants from welfare entitlements (de Koster, Achterberg, and van der Waal 2012). Today, the term is widely used by researchers and similarly implies that welfare benefits should be generous (as they are in most European countries), however these benefits should be restricted to citizens only (Cavaille and Ferwerda 2016a). Many PRR parties have built this notion into their platform to exclude outgroups such as immigrants (Afonso 2014; Cavaille and Ferwerda 2016b; Greer 2017; Kitschelt 2007).

Health policy examples of such an approach for PRR parties could be anything from the immigrant health surcharges proposed in the United Kingdom, to the tobacco regulations implemented in the United States to the exclusion of drug users and "terrorists" from services in the Philippines. In each of these instances the welfare generosity towards the population stays the

same or improves, while that of a certain population group gets worse. For example, by regulating ENDS products, policy makers did not account for flavors that were most common amongst non-white populations (including cigarillos and menthol cigarettes). So, rather than targeting policy at all tobacco products used by youth, the Trump administration acted in 2019 to ban certain flavors for ENDS products only (Singer and Willison, 2021).

In addition, we can expect the core positions of the PRR with regards to health to follow an anti-scientific path. We can see this with regards to smoking with the Austrian FPÖ reneging the smoking ban (discussed in Chapter 4) or Mike Pence's statement that 'smoking doesn't kill' (Scott L Greer, 2017). Similarly, the PRR Lega in Italy as well as former President Trump promoted the idea that vaccines cause autism. Many more examples of anti-scientific rhetoric can be found in Chapter 8 when I look at the impact of the PRR during the COVID-19 pandemic.

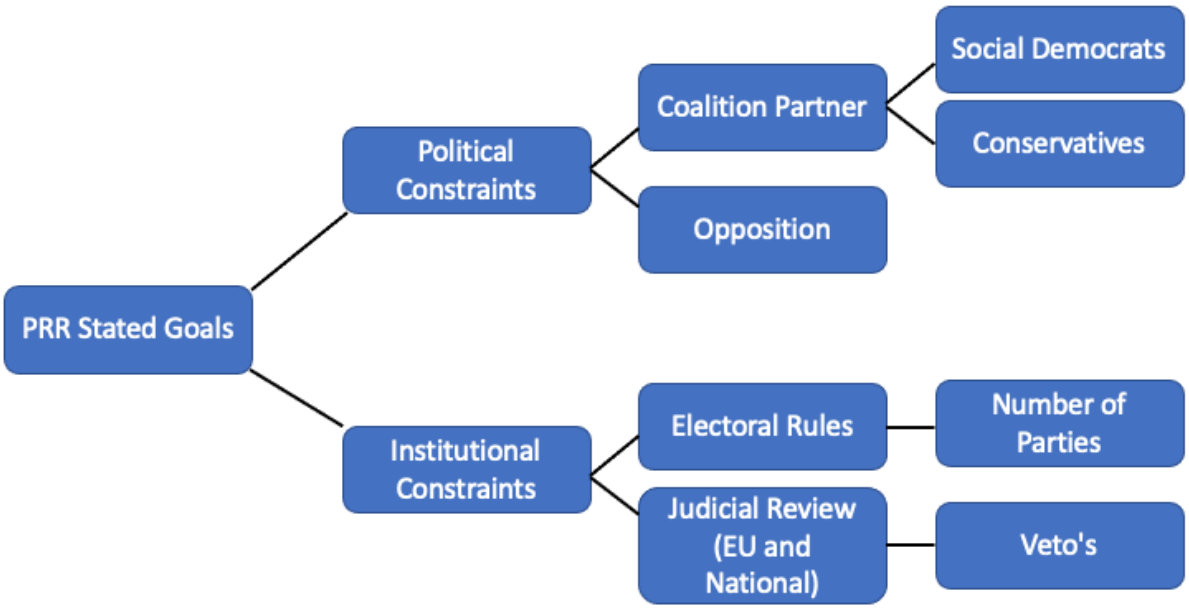
Looking more closely at the welfare chauvinist model, it is apparent that the concept of generous welfare provisions for citizens coupled with the restricted access and provisions for foreigners directly plays into the PRR ideology of nativism. Within the literature, two different sides of this model are discussed. One focuses predominantly on the demand side of politics (voter preferences) while the other side is more concentrated on the supply side of politics (party policy and ideology). The demand side stands to explain the emergence of the PRR altogether as many voters feel that immigrants should not be immediately entitled to social benefits upon arrival (Bonal & Zollinger 2018) often identifying them as the least deserving social group (Ennser 2020). Why and to what degree voters embrace welfare chauvinistic policies and attitudes is made up of a number of different influencing factors: viable alternatives to the traditional mainstream parties during economically insecure times (Michel, 2017), low cultural capital (van Oorschot 2000 & 2006), the previously mentioned feeling of economic inequality,

and cultural heterogeneity (Reeskens 2012). In the supply side research, scholars have highlighted welfare chauvinism as central in the policy approaches mentioned in party programs. PRR manifestos have been extensively researched and it is clear that this party group favors welfare chauvinistic policies (Careja 2016, Heinisch 2019 & 2020).

What is not entirely clear however, is whether there are distinct circumstances that must be in place for PRR parties to favor one approach over the other. What also remains unclear from this literature is whether a given welfare approach also applies to a PRR parties health policy choices. This research will build on these theories and identify under which specific circumstances PRR parties engage in welfare chauvinist vs. liberal chauvinist policies. In order to accomplish this knowing when PRR parties shape policy can be particularly helpful.

There are many factors that influence the impact of a political party on policy as can be seen in the figure below summarizing the key factors that stand between PRR parties, in particular, and policy impact.

Figure 3 Impact of the PRR on policy



Source: Adapted from (Falkenbach & Greer, 2018)

On the one side, there is a set of political and institutional constraints on the PRR party. Electoral rules determine the effective number of parties in a party system, with proportional representation systems increasing the number of parties. The effective number of parties in most party systems has been going up in most European countries for some time, regardless of electoral rules, as party systems fragment, and the previously dominant Social Democratic and Christian Democratic parties' decline. In party systems with more parties, governments require coalitions. The PRR parties in European national governments have almost all entered government in coalition with established conservative, mostly Christian Democratic, parties (the exception is Italy[7]). There are very few examples of the Social Democrats in any country working with the PRR[8]. In a coalition government, both the coalition agreement and the partner party constrain what the PRR party can do to pursue its goals—for example, welfare chauvinist objectives might be turned into exclusionary liberalism if the conservative coalition partner, for example, is willing to endorse anti-immigrant policies in return for PRR support for budget cuts. This factor has a further implication. So far, the PRR has only entered government in coalition governments in countries with proportional representation. In countries whose institutions make them more prone to have single-party governments with extensive power, such as the United Kingdom or France, a PRR government could be unconstrained and very powerful.

The second major external constraint is the rule of law, especially constitutional judicial review, but also lower forms of law such as administrative public law review and international

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[7] The Italian government was made up of the PRR Lega under Matteo Salvini and the left-wing populist 5 Star Movement under Luigi di Maio in 2018. This government lasted until 2019.

[8] The most known example is the "Sinowatz" government in Austria where Social Democratic chancellor Fred Sinowatz formed a coalition government with the PRR FPÖ in 1983. This lasted until 1986. However, the FPÖ at this time is described as being more liberal and less confrontational (Bischof and Plasser, 2008).

law such as that of the European Union. PRR policies, whose explicit goal is often discrimination, can very frequently run into trouble with rights protection and antidiscrimination law. The effectiveness of courts and the strength of rights protection varies widely, and courts often find it difficult to prevail when an elected government seeks to undermine them. In the short run, however, they can block PRR policy initiatives.

The third factor affecting the impact of the PRR is simply their actual, revealed, policy preferences. It is harder to blur goals when in government as opposed to when campaigning. PRR parties might, for example, decide that anti-immigrant policies are more important to them and their voters than living in a generous welfare state. Even in an age of weak party organizations, PRR parties are often particularly top-down and short on activists (the name and logo of the Five Star Movement in Italy are literally the property of its leaders Beppe Grillo and Gianroberto Casaleggio while the Dutch PVV has only two members: its leader Geert Wilders and an association he controls) so they have considerable latitude to make risky decisions.

These three factors are among the many that shape the impact of parties on policy in general, but they have been the dominant ones in the cases of the PRR that we have so far. The PRR is of course also shaped by a force that shapes all parties, which is policy legacies. For example, it is hard to impose new exclusionary laws in self-governing social insurance systems such as that of Austria. All other things being equal, we should expect that the formal impact of the PRR on access to healthcare for legal immigrants should be greater in NHS systems, such as Italy, where the eligibility rules and administration of social insurance do not form obstacles.

What have PRR parties done to implement their views while in power? There are only a handful of articles that provide answers to this question. In 2015, Afonso and Popadopoulos published a piece showing how the rise of the PRR Swiss People's Party (SVP) affected welfare

state reforms in Switzerland between the 1990s and the 2000s. They quote politicians explaining that health is not their focus as it is not a "battle that suits us" such as polices concerning immigration and public safety (Afonso & Papadopoulos, 2015). That same year, Afonso published a piece comparing the welfare reforms of PRR parties in Austria, the Netherlands and Switzerland finding that either the PRR gave into the coalition partner and implemented retrenchment reforms thereby losing the support of core voters (Austria and Switzerland) or they refused the reforms and got kicked out of office by their coalition partner (Netherlands) (Afonso, 2014). In his analysis of the social policies put forward in the election manifestos of the Austrian Freedom Party (FPO) between 1983 and 2013, Ennser-Jedenasik, found that healthcare was not a prominent feature on the FPO's agenda during the time period of investigation. Instead, the party promoted the inclusion of disabled people in social life, and had over the years proposed a number of measures to that end (Ennser-Jedenastik, 2016). In 2017, one article (Röth, Afonso, and Spies 2017) touched on the impact of PRR parties on social policies and one article (Muis and Immerzeel, 2017) contested that more specific research was necessary in order to study PRR impact. Röth et al. (2017) maintain to have offered the first "systematic comparative study" (page 1) of Western European PRR parties' impact on social spending/welfare generosity and economic policies. Although they make salient conclusions, their methods could be seen as incomprehensive. For instance, in the quantitative part of their design they use the Comparative Manifesto Project data to calculate each party's position on social and economic policies, however they are not able to separate redistributive from de-regulative issues making it difficult to differentiate center right politics from PRR politics as the result will likely be more centrist in nature. As for the qualitative analysis, by only choosing one PRR government and one non PRR government within the same country the analysis seems rather weak as it is only reasonably

applicable to Austria, the case chosen for the comparison. In a 2018 article, Afonso partnered with Rennwald suggesting that Bismarckian countries with PRR parties in government tend to follow more exclusionary welfare policies based on an insider-outsider divide, while the Scandinavian and Beveridgian models seem to "move to more conditionality as a radical right parties become stronger" (Afonso and Rennwald, 2018).

While research on PRR social and economic policies exist, none are truly focused on health impact. In addition, most studies are single country studies making it difficult to convince readers that the findings are applicable across PRR governments. Altogether, there is simply not enough research on the impact of the PRR right in government on health policies.

Conclusion

This chapter has first and foremost demonstrated that party's matter in making welfare policy decisions. When looking at parties' impact on the welfare system, social democrats were found to be the main agents of social expansion and egalitarian welfare policies. With their decline and the transition of the party system to include new parties (such as the PRR) within the political spectrum it became essential to deduce what stance PRR parties take with regards to welfare policy.

The literature surrounding PRR welfare policies led to the creation of a model depicting four possible welfare policy directions (Welfare chauvinism, liberal chauvinism, liberal universalism and social democratic universalism), According to the literature welfare chauvinism and liberal chauvinism are the most likely to be pursued by PRR parties in government. The

question that remains is which do they chose for health policies and under what circumstances do they make this decision.

These findings stress that more research is necessary specifically focusing on how the PRR have impacted healthcare and health policies. Given the small number of PRR parties in national governments and the complexity of their effects, it is customary to use comparative qualitative analysis to study them (Falkenbach & Greer, 2018). Chapters 4 and 5 will use this method to shine a distinct light on the national cases of Austria and Italy, while Chapters 6 and 7 will explore the subnational level of these countries. Chapter 8 will then use the COVID-19 pandemic to determine what impact PRR parties in government have on health. Before these chapters are explored, Chapter 3 will outline the dissertations methodology.

Chapter 3 **: Methods**

This dissertation will add to the limited literature through the use of an in-depth case study approach (Morse and Richards, 2002; Zainal, 2007) to understand what the PRR in Austrian and Italian national and subnational governments actually accomplish with respect to health policies. The benefit of this type of qualitative research is the ability to obtain holistic and comprehensive insight into an issue in its natural context (Crowe et al., 2011; Yin, 2003).

European countries vary in a number of substantial ways, including their differing healthcare systems, their regulations pertaining to social and welfare benefits and the norms that govern their political process. The country's political actors vary in their ideologies, how they interact with institutions, other political players and how they make decisions. These substantial variations make it difficult for traditional quantitative methods to effectively capture a telling story of what is happening in these countries (Hennink et al., 2011). The case study approach allows this study to uncover "patterns of diversity" (Ragin, 1987) across my two countries and selected regions within these countries. While examining the cases of Austria and Italy on a national level is valuable, going subnationally gives me additional leverage that a country level analysis cannot provide. According to (Giraudy et al., 2019) advantages of subnational comparative analysis can also be found in substance, theory and methods. Substantively, subnational research allows me to explain the variation inside a country by focusing on political actors and healthcare institutions that are often neglected. In addition, new theories can be created specifically "when subnational observations cannot be explained by national-level

theories" (Giraudy et al., 2019, p 5). Theoretically this approach is useful to avoid attributing subnational theories to explain national outcomes. Methodologically, as previously stated, I am expanding my unit of analysis thereby enlarging my pool of comparative research possibilities. A final reason as to why the use of subnational analysis is particularly fitting for this study is that PRR and/or authoritarian regimes "often persist at the subnational level" (Giraudy et al., 2019, p 9). Furthermore, as we will see in the case of Italy, health policy is not made at the national level, rather each region is responsible for developing a healthcare system.

The case study approach both nationally and subnationally allows me to identify variation and detect common themes which emerge from key-informant semi-structured interviews, archival records, text analysis, and discourses. Additionally, I conducted within-case analysis of each of the countries and the selected regions. This portion of the analytic plan is more focused on the causal mechanism occurring within a country and region over time, using process tracing methods (Tansey, 2007).

There are several other, additional reasons, based on (Morse and Richards, 2002), that I chose a qualitative design approach over a quantitative one: 1) There is not very much literature on this topic and therefore more information is necessary to expand the knowledge in the field. Populism and health policy is profoundly understudied (Falkenbach et al., 2019), which is why I was forced to broaden my scope to include welfare policies, of which health policies are an essential part and not just focus solely on health policies. 2) Populism is a complex system that is constantly adapting and changing making it difficult to understand. Not only is populism a thin centered ideology, meaning it is commonly coupled with other characteristics requiring the differentiation between right and left winged populism, but more recently a distinction has been made as to whether one is speaking about a populist party or a populist leader, or both (populist

practitioners). Thus, in depth analysis of the different situation in within the two countries and four regions will better serve this field of research. 3) This research aims to understand what populists do in government, thus requiring the study of a person's/people's behavior. People's behaviors are difficult to quantify in numbers, specifically when those people are politicians or parties. In this case, it is more fruitful to observe the behavior and ask about the reasoning behind the behavior as opposed to quantifying it. In addition, there is not enough data available to make quantifying it a viable option. 4) One of the goals of this research is to garner a deeper understanding of the nature of populist radical right (PRR) parties in office. Typically, a deeper understanding of a thing of interest requires one to go beyond the numbers and figure out more than: Did PRR parties pass health policies? Rather, the questions for this type of research embraces a more inquisitive style: Why did PRR parties pass health policies or why not? What kind of health policies were passed? Did they follow a more welfare chauvinist model, or could they be classified as neo-liberal?

These are important questions that must be answered to further research in this field. This dissertation will help in establishing a classification for at least two PRR parties (Austria and Italy) and it will identify their tendencies when it comes to health policies. These two points will, in turn, make studying the PRR and their impact on health easier in the future. Once more cases have been evaluated, quantitative studies might then be useful in comparing country cases on a much larger scale.

This chapter will highlight the qualitative methods that I have chosen to answer my research question: What is the impact of the PRR on health (and social policies) at a national and subnational level in Austria and Italy. The chapter will begin by speaking to the qualitative design, then it will go onto the case selection on both national and subnational level for both

countries. Then the interview strategies and textual data collection are discussed and finally the analytical approach is presented. The chapter will end with a section dedicated to the analysis across cases.

What to expect

Qualitative case studies are a useful approach to enhance the understanding of policy decision-making processes as they provide inherent flexibility to use all relevant data and present it in a variety of ways (Anckar 2008). Applying rigorously selected cases and in-depth qualitative analyses enhances findings by further examining the complex relationships and temporality of multiple factors affecting policy decision-making (Anckar 2008). In each case, I collected two types of qualitative data: interviews, and textual document data. Interviews and document analysis add a contextual grounding of the complicated relationships between the multiple factors at work and helped to tease apart the political decision-making processes leading to the outcome with a greater level of detail (Collier 2011). In my cases, the multiple factors at work are party politics, specifically the success of nontraditional parties (PRR), institutional constraints, and policy making. The outcome of interest is what policies (health and social) were actually implemented by PRR parties.

This in-depth case study design begins with a comparative historical analysis on a cross-national, sub-national and longitudinal basis between Austria and Italy in order to determine what can be learned from the political involvement of the PRR in national and subnational governments. The comparative method will help highlight and contextualize policy events and help me to understand the policy decision-making processes that can be used to explain the PRR phenomena beyond a particular time and place (Ritter, 2014). This method will illuminate the

factors associated with different policy choices in the specific context of each country. Not only were cases selected that are representative of the existing heterogeneity from the national sample to improve generalizability, but an additional in-depth analysis of the processes at work in each regional/provincial case was conducted, to gain a more nuanced understanding of the complex processes at work affecting the policy choices made by PRR parties in terms of health and social care.

I will use a Most Similar Systems Design (MSSD) of the Mill's Methods approach to comparative politics (Teune and Przeworski, 1970), which maximizes case selection variation at the level of the dependent variable/s, which in this case are health policies. MSSD will isolate the independent variables, which explain the presence/absence of the dependent variable by extracting contextual data and themes specific to each case (Landman, 2013). The generalizability of the findings will greatly increase by maximizing the variation between the selected cases. In addition, the use of MSSD will also allow for the stratification of the findings across a larger group of cases.

Case Selection

Selection is of utmost importance for case studies. To understand what health and social policies PRR parties follow when in government, I conducted in-depth comparative case studies across two countries (national) and four regions (subnational). For both the national and subnational studies, the typical method of case selection was used because the interest lies within

the two country cases themselves allowing for a better exploration of the causal mechanisms (Seawright and Gerring, 2008).

Figure 4 Populist Radical Right Parties in Government

COUNTRY	RRPP	PERIOD	COALITION PARTNER
Austria	FPÖ	2000 - 2005	ÖVP
	BZÖ	2005 -2006	ÖVP
	FPÖ	2017 - 2019	ÖVP
Denmark	DFP	2001 - 2005	V, KF
	DFP	2005 - 2007	V, KF
	DFP	2007 - 2011	V, KF
Finnland	True Finns	2015 - 2017	Centre, National Coalition, Blue Reform
Greece	LAOS	2011 - 2012	ND, PASOK
Italy	LN	1994 - 1996	FI, CCD-UDC, AN
	LN	2001 - 2005	FI, AN
	LN	2008 - 2011	PdL
	LN	2018 - 2019	5 Star Movement
Netherlands	PVV	2002 - 2003	CDA, VVD
	PVV	2010 - 2012	CDA, VVD
Switzerland	SVP	since 2000	CVP, FDP, SP

Considering Figure 4, I will explain why cases such as Denmark and Switzerland were not selected for this study. While the Swiss Peoples Party (SVP) is the PRR party with the most stable and longest governmental experience, this case was excluded for a number of reasons. To begin with, the Swiss political system does not lend itself to easy comparison with other Western European countries seeing as the Swiss follow a vigorous federal structure both in an institutional sense and a cultural one (Church and Dardanelli, 2005). Research signals that this system is more complex (the element of direct democracy plays a significant role here) and behaviorally motivated than is often realized (Church and Dardanelli, 2005) making comparative attempts difficult. The second significant reason as to why the case was excluded is that political parties in Switzerland do not have the same amount of power that they do in other Western European countries. In fact, all major parties are included in a grand coalition government

resulting in a diffusion of power amongst many actors. This implies that even if the SVP has a strong position within the government, their influence is limited by the other, more liberal actors.

The case of Denmark and the Danish People's Party (DFP) was excluded because the party was not in government with a leadership position on the subnational level. My inferential strategy is based on using both the national and subnational level for leverage in order to control for country effects. Including the case of Denmark would not usefully expand my comparative selection because unlike Austria and Italy it does not offer any subnational leverage that would further contribute to the explanatory results of the research question.

Analytical Approach

I used process tracing as the primary analytic approach. The approach is a data analysis method for identifying, validating, and testing causal mechanisms and how they evolve within a given case (Beach and Pedersen, 2013; Mills et al., 2010). Process tracing is used to build and test theories of processes linking together causes and outcomes within causally similar cases. The process is typically used in combination with comparative methods, but can also be used to gain a greater understanding of the causal dynamics that produced the outcome of a particular historical case (Beach and Pedersen, 2013). Since process tracing is a systematic review of evidence across time, I was able to discern a causal mechanism through the analysis of my case events coupled with the retrieval of key contextual information (Bennett 2010). There are several research objectives that process tracing helps a researcher to achieve (see (Collier, 2011)), in the case of my research these objectives are: 1) to identify novel political and social phenomena and systematically describing them 2) gaining insight into causal mechanisms. A further note, seeing as process tracing seeks a historical explanation for the individual case in question, the goal is to

document whether or not the sequence of events within the case at hand fits those predicted by alternative explanations of the case (Bennett 2010). This historical explanation allows for a deeper an understanding of the mechanism involved in each individual case, which subsequently helps to create larger theories pertaining to a potential macrophenomena (Bennett 2009).

Furthermore, according to (Falleti and Lynch, 2008), these mechanismic explanations have a primordial ontological status in the social sciences (p. 338) seeing as they allow for causation analysis and not just correlation. My mechanismic explanation rests primarily on the third trope presented by Falleti and Lynch, namely that of narrative. This dissertation aims to tell a rhetorically and logically persuasive story so that the hypothesis takes the reader from input to output.

National: Austria and Italy

The cases of Austria and Italy were selected as they are typical and representative examples of countries that have had PRR parties, The Austrian Freedom Party (FPÖ) and the Italian League (Lega), in government over a long period of time. In addition, the FPÖ and Lega are close allies within the nationalist groups in Europe (Balmer, 2020; Bracco et al., 2018), they are also among the oldest, most stable and most established cases of the populist radical right party family in Europe and can be seen as prime examples of right wing populism that is predominant in contemporary Europe (Plescia et al., 2019).

While the FPÖ was in government for the first time in 1983 (see Table 1), this was at a time when the party was not yet considered PRR, rather liberal focusing on free market and anti-statist policies (Bischof and Plasser, 2008). The party did not become PRR until Jörg Haider took over in 1986. Thus, the beginning of the national analysis will begin in the year 2000 when the FPÖ first entered into national government as a PRR party under the direction of Haider. The

years of national analysis will be from 2000-2003, 2003-2007 and 2017-2019 wherein Haider headed the FPÖ from 2000-2003 (although not taking on the position of Vice Chancellor[9]), the FPÖ split into the PRR party BZÖ (Alliance for the Future of Austria) in 2004 with Haider taking over the BZÖ and the FPÖ disappearing from government. This split was due to discrepancies concerning the direction of the party (see chapter 4). With Haider's death in 2005 the BZÖ lost its flame and died out after it was voted out of office in 2007. What this implies is that Haider held the party together and without his leadership the usual factional fighting within the FPÖ (nationalist vs libertarians) recommenced making it an unvotable party. The FPÖ spent several years regrouping after Haider's death under the new leadership of Heinz-Christian Strache. Strache moved the party further to the right on the political spectrum which gained him much approval from voters and would eventually lead the party into a governmental coalition in 2017.

The situation in Italy is slightly more complicated. The Lega was initially founded by Umberto Bossi as a separatist party known as the Lega Nord (Northern League), the name of the party did not change to Lega until 2018 in the run up to the 2018 general elections (see chapter 5). As the Lega Nord, the party was predominately separatist in nature, however it embraced a eurosceptical attitude after the Euro was adopted in 2000 and began directing its attention to non-European immigration as a threat to the Northern Italian identity (Hopkin, 2004). Thus, the Italian analysis will begin in 2001 when the Lega Nord (LN) joined forces with Silvio Berlusconi's business firm party Forza Italia (FI). Although the LN did not have a significant

[9] The Vice-Chancellor stands in for the Federal Chancellor should the Chancellor become ill, die or become otherwise hindered. In practice, the Vice-Chancellor is generally the leading member of the junior party within the current coalition government. S/he is also frequently the party chairman.

governmental role between 2001-2006, it did hold the Ministry of Labor and Social Security making it an interesting time period of study. Similarly, the LN's 2008-2011 time in government was perhaps less significant, however the party was given the Ministry of Interior as well as the Ministry of Federal Reforms. The period between 2018-2019 is of special relevance as this is the first time the party was given the position of deputy prime minister making it more than just a small part of the government rather an equal player with an equal among of ministerial positions.

See Tables 1 and 2 below for the national case selection time periods (below the solid black line). See also the ledger to explain the party abbreviations in the table.

Table 3.1 National Case Selection Austria

Year	Chancellor	Government
1983	SPÖ	SPÖ/FPÖ
1986	SPÖ	SPÖ/FPÖ
1987	SPÖ	SPÖ/ÖVP
1990	SPÖ	SPÖ/ÖVP
1994	SPÖ	SPÖ/ÖVP
1996	SPÖ	SPÖ/ÖVP
1997	SPÖ	SPÖ/ÖVP
2000	ÖVP	ÖVP/**FPÖ**
2003	ÖVP	ÖVP/**FPÖ**-**BZÖ**
2007	SPÖ	SPÖ/ÖVP
2008	SPÖ	SPÖ/ÖVP
2013	SPÖ	SPÖ/ÖVP
2016	SPÖ	SPÖ/ÖVP
2017	New ÖVP	New ÖVP/**FPÖ**
2019	Independent	Technocratic
2019	New ÖVP	New ÖVP/Green

AUSTRIA
SPÖ ➔ Social Democratic Party of Austria
ÖVP (until 2018) ➔ Austrian People's Party
ÖVP new ➔ The new Austrian People's Party
FPÖ ➔ Freedom Party of Austria
BZÖ ➔ Alliance for the Future of Austria
Green ➔ The Green Alternative

Table 3.2 National Case Selection Italy

Year	Prime Minister	Government
1994	Forza Italia	FI–LN–**AN**–CCD–UdC
1995	Independent	Independent
1996	The Olive Tree	Center Left
1998	The Olive Tree	Center Left
2000	The Olive Tree	Center Left
2001	Forza Italia	FI–**AN**–LN–UDC–NPSI–PRI
2006	The Olive Tree	Center Left
2008	The People of Freedom	PdL–LN–MpA
2011	Independent	Independent
2013	PD	PD–PdL/NCD–SC–PpI–UdC–RI
2014	PD	PD–NCD–SC–UdC
2016	PD	PD–NCD/AP–CpE
2018	Independent	M5S & L
2019	Independent	M5S & PD

ITALY
FI ➔ Forza Italia
LN ➔ Lega Nord
AN ➔ National Alliance
CCD ➔ Christian Democratic Center
UdC ➔ Union of the Center
NPSI ➔ New Italian Socialist Party
PRI ➔ Italian Republican Party
PdL ➔ The People of Freedom
MpA ➔ Union for the Autonomies
PD ➔ Democratic Party
NCD ➔ New Center Right

SC ➔ Civic Choice
PpI ➔ Italian People's Party
RI ➔ Reality Italy
AP ➔ Popular Alternative
CpE ➔ Centrists for Europe
L ➔ Lega
M5S ➔ 5 Star Movement

Subnational: Carinthia, Burgenland, Lombardy and Veneto

The main criteria in this case selection was that the regions and provinces chosen had to have had a PRR governor or deputy governor over a period of time. This means that being a part of the subnational governmental coalition would not fully meet the criteria required for case selection. The reason for this specific criterion is that when a party is given the governorship or the deputy governorship, they are also given more ministries in the provincial government, thereby increasing their overall influence. For example, while the provinces of Salzburg, Upper and Lower Austria, Styria and Tyrol included the FPÖ in their governmental coalitions, the FPÖ did not hold the position of governor or deputy governor and thus these cases were excluded. There are two reasons why a party can be a part of the subnational government, but not hold the position of governor or deputy governor. The first is that the province still supports proportional representation (Proporzsystem), as is the case in both Upper and Lower Austria. The system of proportional representation, applied in every province until the 90s[10], allows positions in government to be distributed in a manner proportional to their electoral or public support. The original goal behind this Proporzsystem was so that the two biggest parties (ÖVP and SPÖ) could consolidate their power in each of the provinces seeing as the smaller parties (FPÖ and Greens) were too insignificant to meet the threshold. In the case of the 2018 state election in Lower Austria, the ÖVP was able to hold their state parliamentary majority with six out of the nine state councilor seats, the SPÖ was able to uphold their two seats and the FPÖ won one seat. Since the ÖVP won the majority, they got to place the governor and the deputy governor was

[10] Excluding Vorarlberg, where the Proporzsystem was already abandoned in 1923.

placed by the runner up – the SPÖ. The FPÖ in Lower Austria, therefore, did have a single council position in the state parliament, but had no leverage to make any significant decisions.

The second reason that a party can be a part of the subnational government, but not hold the position of governor or deputy governor is if the election winner chooses to form a coalition with them. Taking, for example, the 2018 election in Salzburg, the ÖVP won the majority of votes. However, the ÖVP did not have the absolute majority (15 out of 36 seats) and therefore needed to choose a coalition partner. Instead of choosing the SPÖ with 8 seats, which would have given the two parties the majority, the ÖVP opted instead to form a coalition with the Greens (3 seats) and the NEOS (3 seats). This situation resulted in the ÖVP being able to designate the governor and the deputy governor while the Greens and the NEOS were each just given one position in the state government. For the purposes of this dissertation, it is of limited use, specifically for the case of Austria, if a party has only one position in the state parliament.

A further criterion was that the party had to be considered PRR by my definition (see chapters 1 and 2) as informed by the literature. With Austria, this turning point came when Jörg Haider took over the FPÖ in 1986 (Ennser-Jedenastik, 2016) and in Italy this came in 2000 with the introduction of the Euro (Hopkin, 2004). Therefore, any FPÖ or Lega governorships or deputy governorships before 1986 and 2000 will not be considered.

Beginning with the Austrian subnational case, only two of Austria's nine provinces had a history of having the FPÖ in government (Carinthia and Burgenland). Even though the FPÖ in Vorarlberg was made junior partner in the ÖVP coalition government from 1984 until 2009, their influence was insignificant. Between 1984 and 1999, and again from 2004 to 2009, the FPÖ only had a single councilor representative within the state parliament. Between 1999 and 2004, the solitary councilor was made the Vorarlberger equivalent of deputy governor, however the ÖVP

state parliamentary majority remained (6-1). This is to say that while the FPÖ was represented within the Vorarlberger state parliament, it only had one representative at all times compared to the six the ÖVP had. Thus, the case was excluded as their influence was slim to none.

That left me with the cases of Burgenland and Carinthia. In Burgenland, the FPÖ held the deputy governor position as well as one other position within the state parliament between 2015 and 2020. In Carinthia the FPÖ/BZÖ positioning was much greater. Haider held the position of governor from 1989 until 1991 with no other FPÖ council members meaning the state parliament was made up of Haider (FPÖ), four SPÖ council members and two ÖVP council members. The case was kept because Haider had the governorship. Between 1991 and 1999 the FPÖ held two council positions, but no position of leadership within the parliament, thus those years were excluded. Starting in 1999 the FPÖ held both the governorship of Carinthia as well as the deputy governorship and had a regular councilor as well. This gave the FPÖ 3 councilors, the SPÖ 3 and the ÖVP 1. This constellation remained until 2009 despite splits within the FPÖ. In 2005, Haider formed the BZÖ and after his death this party became the FPK. Also in 2005, after Haider's death, the FPK took 4 councilor positions in the state parliament including both the governor and the deputy governorship. Given these explanations Carinthia and Burgenland were the only cases that made sense to choose for the analysis (See Tables 3 and 4).

The analysis in Carinthia will begin in 1989-1991 when Haider was first elected governor and will continue from 1999 until 2013 when the BZÖ lost the governorship to the SPÖ. The case will however, most strongly focus on Haider and his time in government (up until his death in 2005) because that was when the party had the most power and influence.

While the FPÖ in Burgenland were in government from 1996 until 2000 they only held one ministry and were not given the position of governor or deputy governor, therefore, the

analysis for this province, as previously mentioned, will begin in 2015 when long time governor of Burgenland, Hans Niessl (SPÖ), decided to form a coalition with Burgenland's FPÖ making Johann Tschürtz deputy governor. This coalition was upheld until 2020 when the SPÖ won the absolute majority in the province and no longer needed a coalition partner.

To summarize, to be considered for case selection, the FPÖ had to have held at least two portfolios in the state parliament, wherein one of those must have been at least the deputy governorship, if not the governorship. This is pertinent as I am going in-depth and looking for leverage therefore, I need cases where the PRR was part of the core executive.

Table 3.3 Case Selection Carinthia

Year	Governor	Coalition
1980	Leopold Wagner III	ÖVP/**FPÖ**
1985	Wagner IV/Ambrozy	ÖVP/**FPÖ**
1989	**Haider I**	SPÖ/ÖVP
1991	Zernatto I	SPÖ/**FPÖ**
1995	Zernatto II	SPÖ/**FPÖ**
1999	**Haider II**	SPÖ/ÖVP
2005	**Haider III / Dörfler I**	SPÖ/ÖVP
2010	**Dörfler**	SPÖ/ÖVP
2013	Kaiser	ÖVP/Green/**FPÖ**/TS
2018	Kaiser II	ÖVP

Table 3.4 Case Selection Burgenland

Year	Governor	Coalition
1982	Theodor Kery	ÖVP
1986	Kery / Hans Sipötz	ÖVP
1991	Karl Stix	ÖVP
1996	Karl Stix	ÖVP/**FPÖ**
2000	Stix / Niessl	ÖVP
2005	Hans Niessl	ÖVP
2010	Hans Niessl	ÖVP
2015	Hans Niessl	**FPÖ**
2019	Hans Peter Doskozil	**FPÖ**
2020	Hans Peter Doskozil	SPÖ

AUSTRIA
SPÖ ➔ Social Democratic Party of Austria
ÖVP (until 2018) ➔ Austrian People's Party
ÖVP new ➔ The new Austrian People's Party
FPÖ ➔ Freedom Party of Austria
BZÖ ➔ Alliance for the Future of Austria
Green ➔ The Green Alternative
TS ➔ Team Stronach

In Italy, out of the 20 regions, I narrowed the scope of my focus to Northern Italy (eight regions; see Figure 5) for three distinct reasons: 1) It is the macro-region in which the PRR Lega first developed. The Lega was created in 1991 as a regionalist populist party (Albertazzi et al., 2018) under Umberto Bossi[11]. It was established as a federation of six regional parties of northern and north-central Italy (Lombardy, Veneto, Piedmont, Liguria, Emilia Romagna and the Toscana) whose primary goal was to split Italy in two – North and South – so that the rich north would no longer have to pay for its much poorer Southern counterpart. Not until Salvini took over the party from founder Umberto Bossi in 2013 was there a move to win over voters in the more southern and central regions. 2) It is where the majority of regular immigrants are located (Colombo and Sciortino, 2004), making it ideal to research PRR inclusion and exclusion tendencies. 3) Northern Italy is highly representative of the wealthiest and most densely populated regions of Europe (Abbondanza and Bailo, 2018). It is also a structural component of the so- called 'Blue Banana[12]', also known as the 'Industrial Pentagon'[13], which covers the world's highest concentration of people and industries and has the highest GDP per capita (Bosse et al., 2013). 4) Its healthcare system is more comparable, in quality, to its northern neighbors (Ferré et al., 2014).

[11] The Lega did not turn PRR until Salvini took over in 2013 (Brunazzo and Gilbert, 2017).
[12] approximately the areas of London, Benelux countries, South-west Germany, Switzerland and Northern Italy. See (Bosse et al., 2013).
[13] Milan, Munich, Paris, London and Hamburg. See (Bosse et al., 2013).

Figure 5 Map of Northern Italy

Looking at the eight Northern regions, I can further narrow down the scope by excluding regions where the Lega has never been in government. This would leave the regions Piedmont, Lombardy, Veneto, Friuli-Venezia Giulia, Trentino and the Aosta Valley. Of these six regions, the Aosta Valley was excluded because the Lega was only in government one time and that for a very short period of time in 2018. Trentino was excluded because the Lega just recently made it into government in 2019 and thus it is still too soon to evaluate their impact in that region. Friuli-Venezia Giulia was excluded because the Lega held the governorship only once post 2013 and that was in 2019 making it too recent to efficiently study. While the region of Piedmont was run by a Lega governor from 2010 until 2014, the case was excluded for two reasons: First, Piedmont's inclusion would then result in an unequal number of subnational cases. Secondly, Veneto and Lombardy are the two regions generally known as Lega strongholds, and have therefore had a consistent Lega government over time making an analysis of health policies more reliable (See tables 5 and 6).

Table 3.5 Case Selection Lombardy

Year	President	Coalition
2000	Roberto Formigioni II	FI **LN** AN CDU CCD
2005	Roberto Formigioni III	FI **LN** AN UdC
2010	Roberto Formigioni IV	PdL **LN**
2013	**Roberto Maroni**	**LN** FI FdI
2018	**Attilio Fontana**	**L** FI FdI

Table 3.6 Case Selection Veneto

Year	President	Coalition
2000	Giancarlo Galan II	FI **LV** AN CDU CCD
2005	Giancarlo Galan III	FI **LV** AN UdC NPSI
2010	**Luca Zaia I**	**LV** PdL
2015	**Luca Zaia II**	**LV** FI

ITALY
FI ➔ Forza Italia
LN ➔ Lega Nord
AN ➔ National Alliance
CDU ➔ United Christian Democrats
CCD ➔ Christian Democratic Center
UdC ➔ Union of the Center
FdI ➔Brothers of Italy
LV ➔ Venetian League – Lega Nord
NPSI ➔ New Italian Socialist Party
L ➔ Lega

Therefore, the regions, Veneto and Lombardy were chosen to represent Northern Italy and the Italian case study in my dissertation. Veneto and Lombardy are both considered Lega strongholds (Cento Bull, 2009) and have been chosen as cases because the Lega has consistently been in government since the 90's. In Veneto since 2010 and in Lombardy since 2013 there has been a Lega governor. In other words, I am maximizing the odds of finding Lega impact that is unconstrained by a coalition partner. This is essential because the goal of my dissertation is to analyze the impact of the Lega on health.

Semi-structured Interviews

Within each of the two countries (including the five selected cases) semi structured interviews were conducted. A semi-structured format allows the researcher enhanced flexibility to explore new ideas during the interview, which can increase the responsiveness of the interviewee (Frenchtling et al., 2002). Despite its semi-structure nature, this interview format still used a set of pre-determined themes derived from the research questions and factors of interest (Warren, 2001) (see Appendix). Political actors as well as researchers and professors were asked a series of open-ended questions to help engage them in sharing their experiences and perspectives as to what PRR parties accomplished in government in terms of health and social policies. To increase validity, the interviews were triangulated with official documents, previously published research and news media. 40 semi-structured interviews with political scientists, healthcare researchers, health policy makers and politicians have not only helped clarify the historical significance of both countries and their selected regions but have also helped to explain the national and subnational policy choices that were made over time.

Interview Sample

The interview sample included a mix of political actors within the national and regional healthcare systems as well as health policy or political science researchers or professors based in the different regions. For each country case, I recruited 20-25 interviewees (See Appendix D). This sample size was chosen in order to keep the number of interviews feasible for the completion of in-depth, in person interviewing and large enough, on the other hand, to obtain useful information. I interviewed each group until I reached saturation, which means that no new additional information was obtained from the interviews. This is important because it enhances reliability (Warren, 2001).

I found it particularly difficult to obtain political actors in Austria from the FPÖ party. Most simple did not respond to my inquiry. It was also difficult to locate interviewees that had both a knowledge of Austrian healthcare and Austrian politics. Many of the healthcare experts that I contacted declined to be interviewed due to the fact that they are not knowledgeable about FPÖ politics. I overcame this challenge by interviewing health experts, Austrian health and political science researchers and Austrian political scientists. Although researchers and experts are typical partisan, I was not able to detect bias for or against the FPÖ within our interviews.

I began interviewing my Italian subjects in the summer of 2018 as preliminary research for my dissertation. While I tried to obtain meetings with politicians in the regions I ultimately selected for my cases (Lombardy and Veneto) none came to fruition despite. Between the fall of 2018 and the fall of 2019, I decided to conduct my interviews pertaining to Italy at the European Public Health Conference (in Ljubljana and Marseille, respectively). Here I contacted health experts and people affiliated with regional politics prior to the conferences and proceeded to

interview them during intermissions. While I received some interesting information regarding the Italian healthcare system as a whole and how healthcare works in certain regions, I was missing people familiar with the regions of Veneto and Lombardy. With the outbreak of the COVID-19 in the early months of 2020, my planned Northern Italy trip for interviews was canceled and I was only able to interview two of the subjects over the internet as all others canceled. Given the travel restrictions placed on Italy, I will likely not be able to finish my interviews in person. As previously mentioned, this has presented a problem in the past as people, specifically politicians, are reluctant to schedule meetings online. To overcome the shortage of interview partners pertaining specifically to the regions of Lombardy and Veneto, I used a similar strategy to the one I employed for Austria – namely looking more towards Italian health and political science researchers and Italian political scientists.

Interview Approach and Questions

The interviews were conducted in an iterative process. Cold Emails, professional social media sites (researchgate, linkedIn), word of mouth and conferences were used to establish contact and schedule interviews. Due to the fact that this research falls under the IRB (International Review Board) exempt category two, recording of the subjects was possible as there was only minimal risk to the subjects. Therefore, all interviews were recorded and transcribed.

A combination of snowball sampling and quota sampling ensured that representation was based on: (a) geographical region, (b) relation to healthcare system, (c) if applicable, political affiliation. The snow-ball sampling approach (Biernacki and Waldorf, 1981) was taken, despite its risk of inconsistency, as this was the best way to reach interviewees that have substantial

knowledge of the healthcare system as well as insights into the political parties and systems. In addition, politicians, specifically right winged ones, are not always willing to speak to researchers and also do not believe in the value of research, therefore snowballing was the best way to obtain a larger sample of this group as well as of people willing to discuss right winged politics in general. I also followed quota sampling, which implies that the choice of the actual sample units is left up to the interviewer (Moser, 1952). This sampling method was specifically chosen because I previously decided on the breakdown of the sample, but I just did not know how many people I would be able to attain for each category.

The interview template (see Appendix F) I used to complete my semi-structured interviews eased into the discussion with a general, easy to answer question not necessarily relevant for my research. This initial question changed from interview to interview as it depended very much on whom I was speaking with. The following questions focused on the interviewee's experiences with the PRR party or actor in question. This could range from how they saw them as governing partners to how they would analyze the health policy decisions implemented by PRR in government to the general impact of PRR in government.

Document Analysis

Document and interview coding occurred in an iterative process using the software MAXQDA, a qualitative software package for qualitative data organization and analysis. Coding is a heuristic, meaning it is an exploratory technique that helps in problem solving without having to rely on set formulas to follow (Saldaña, 2009). Coding was used in this dissertation to link data (in this case document analysis and interviews) to ideas (Richards and Morse, 2007). The software MAXQDA aided in the organization, coding, mapping of the decision-making processes and the

establishment of inter-coder reliability for all interviews and textual sources. The generated codes (see Appendix A) were then grouped into themes using a deductive and latent approach. A deductive approach was chosen because I already had several preconceived themes that I was expecting to find based on my literature review and the theory surrounding PRR parties.

I triangulated between interviews, official documents, media news and previously published research to effectively establish what health and social policies were enacted by PRR parties in government as well as why other policies failed to be implemented. The document coding and interview coding occurred in an iterative process.

I conducted open coding to allow for other, non-pre-determined themes to arise from the data and I enlisted a secondary coder to code for inter-rater reliability thereby enhancing the validity of the measurements.

Text Data

I collected archival documents at national and regional/provincial levels to provide an institutional context behind the policy decision made during the PRR governments. This body of text includes laws and regulations passed at both the state and regional/provincial levels on relevant policies such as the health insurance mergers in Austria, the revocation of the No Smoking Act or the "evolution of the social and healthcare system in Lombardy". At the national level in Austria, I used the publicly available parliamentary database www.parlament.gv.at as well as the legal database https://www.ris.bka.gv.at/. The same strategy was used at the Italian national level using the publicly available parliamentary database www.parlamento.it/home and the legal database https://www.gazzettaufficiale.it. At the regional/provincial level, I visited each regional and provincial website to determine if any relevant health or social policies were passed

during my time of study. The analysis of legal and historical documents has built the framework for the comparative analysis of both countries and supplement as well as complement the interviews giving a holistic and thorough picture of the PRR's impact on policies.

Analyzing Across Cases

A cross case analysis is one that seeks to examine themes, similarities and also differences across cases by teasing out the complex processes involved in policy development (Mathison, 2005). Process tracing also aids in this process by examining the main factors at work thereby extracting themes in order to compare findings across individual cases. Comparing results across different cases allows me to understand and theorize how political decision-making is influenced by contextual arrangements in each case –institutional structures, ideology, economic and social factors, and existing lateral policies – to be able explain the relationship between context and divergent policy outcomes.

This form of analysis provides me with a template for exploring the similarities and differences of my cases in a way that supports their generalizability and theoretical predictions. This analysis will present itself in the final chapter of the dissertation when I analyze my cases in comparison to one another with particular focus on how the PRR in the discussed cases responded to the corona pandemic. The analysis will allow for the emergence of generalizable themes that can then be used to address similar issues (the PRR in government and their impact on health) in other countries.

Conclusion

This chapter has demonstrated the methods used in my dissertation and the next chapters will showcase their application. Chapter 4 will explain the national case of Austria and highlight the impact of the PRR on health and social policies at the federal level, while Chapter 5 will do the same looking at the subnational level. Chapters 6 and 7 do the same things for Italy (national and subnationally). Chapter 8 will apply the concepts discussed in the previous chapters to the COVID-19 pandemic and the final chapter will conclude the dissertation.

Chapter 4 **: The National Case of Austria**

"The FPÖ has absolutely no impact on health whatsoever, you are wasting your time."

- Hans-Peter Doskozil (SPÖ)

This chapter will begin by looking at the Austria system including its welfare model and healthcare system. Then the chapter will proceed to the case of the FPÖ in national government. A history of the FPÖ tracing their transition from a predominantly welfare populist party in government into one that adapted a welfare chauvinist approach to governing will be given. Then the chapter will move into the history of the FPÖ tracing their transition from a predominantly welfare populist party in government into one that adapted a welfare chauvinist approach to governing. Health-related policy decisions, both indirect, through social policies, and direct, through health policies, will be traced back to the year 2000 when the FPÖ first entered into the national government coalition[14]. A short section will reflect on the FPÖs reaction to the COVID-19 and the conclusion will summarize the findings. The goal of this chapter is twofold: 1) to lay out what the FPÖ actually does in government with regards to social and health policies and 2) to establish what type (welfare populist, chauvinist, liberal or conservative) of health and social policies the FPÖ pass when in government. The result will be a detailed account of what the FPÖ

[14] The FPÖ was in a governmental coalition with the SPÖ between 1983 and 1986, however at that time the FPÖ was classified as a more liberal party (Huber, 2009).

accomplished in terms of health and social policies during their time in government and subsequently what impact these policies had on the Austrian population.

The Austrian System in Brief

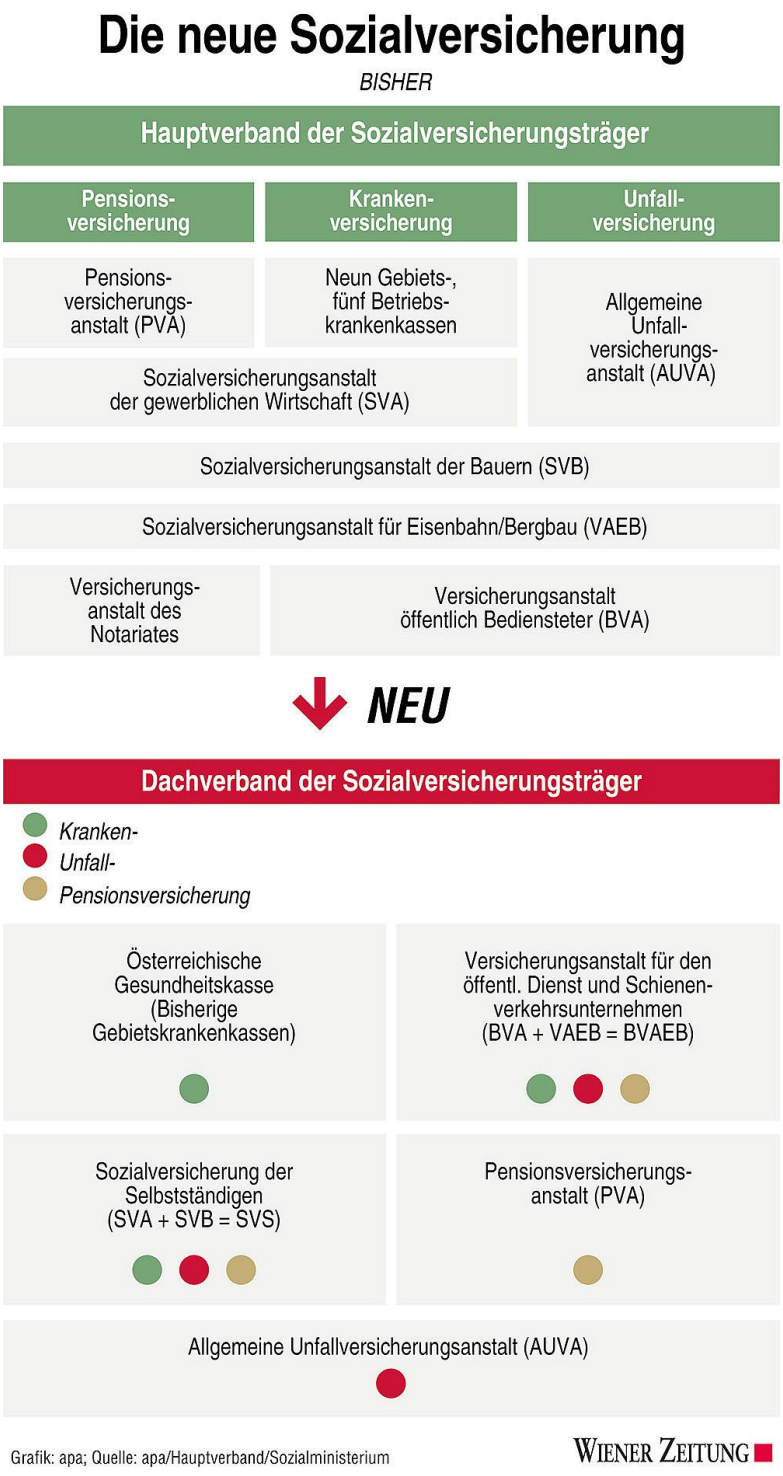
Austria is a landlocked country with 8.66 million inhabitants (Statistik Austria, 2015), of whom 51.2% are women (Hofmarcher, 2013b). Being a federal, parliamentary, representative democratic republic, each of the nine "Länder", except for Vienna, is divided into administrative regions, then branching into local authorities. The federal legislative power is divided between the government and the two chambers of parliament known as the national and federal councils. The judiciary system is solely federal, independent of the legislative and executive branches, meaning there are no state courts in Austria.

Social Insurance System

The Austrian social insurance system contains three separate branches of insurance: health, accident and pension. These were represented within 22 insurance companies belonging to the umbrella organization Hauptverband der österreichischen Sozialversicherungsträger (Hauptverband) or the "Main Association of Austrian Social Security Institutions" until the ÖVP/FPÖ coalition government (2017-2019) changed the number of insurance companies to 5. This change saw the merger of the nine (one for each of the nine federal states) different regional health insurance funds (GKKs), covering most private-sector employees, into one common "Austrian Health Fund" (ÖGK) see Figure 6. The ÖGK, however, continues to have nine district branches, equipped with some managerial powers. The five company-based occupational health insurance funds (BKKs) had the opportunity to either opt into the Austrian Health Insurance

Fund, or to continue to exist independently as “private welfare providers”. The insurance institutions for trade and industry (SVA) and for farmers (SVB) were merged into a common insurance institution for the self-employed (SVS). Similarly, the insurance institutions for public service employees (BVA) and for the railway and mining industries (VAEB) were merged into a joint insurance institution, administering pension, health and accident insurance for these groups BVAEB. The pension insurance fund PVA and the accident insurance fund AUVA stayed mostly as they were. As can be seen, insurance holders are not able to freely choose their insurance fund, which means that there is also no regulated competition between the insurance funds (Hofmarcher M. M., 2013b).

Figure 6 Change in Austrian Social Insurance System



Source: (Pecher, 2018).

Most social policy fields, health included, fall within the legislative competencies of the national government (Article 10, 12 B-VG). There are two factors that play a role within the health system, the social insurance funds, as described above, and the hospitals. The health insurance funds attain their revenue through employee and employer contributions meaning that the Länder have a financial connection to the social insurance funds, however they have limited control over the social insurance funds (Obinger, 2005). Hospitals, on the other hand, fall more heavily into the Länder jurisdiction. The national government is responsible for setting up the framework legislation while the Länder are given the responsibility for the more detailed legislation, for the implementation and for guaranteed hospital care within each province (Mätzke and Stöger, 2015).

The social insurance funds are a part of the social protection system in Austria. The Austrian social insurance system contains three separate branches of insurance: health, accident and pension. Insurance holders are not able to freely choose their insurance fund, which means that there is also no regulated competition between the insurance funds (Hofmarcher M. M., 2013b).

The Healthcare System

Austrian health insurance makes up one part of the Austrian social insurance system. The system was founded on the Bismarckian principles, which, as opposed to the Beveridge national health insurance system, is a social one based on contributions from wages. The general difficulty within the Austrian healthcare system is that healthcare is represented by a number of different actors, and therefore the complexity of the setup often gets in the way of its efficiency.

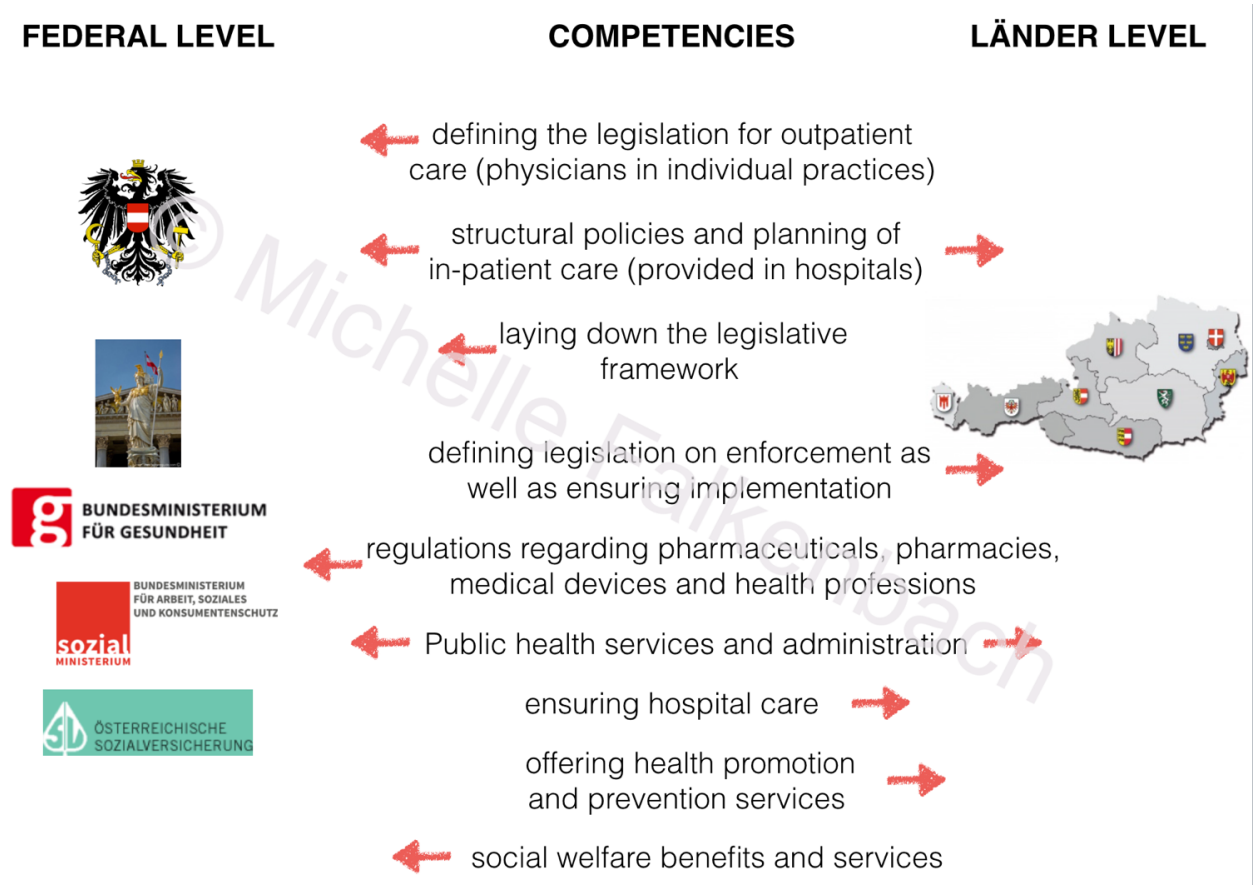
There are three characteristic features of the Austrian healthcare system: Firstly, healthcare competencies are shared between the state (federal government) and the nine Austrian provinces or Länder. Secondly, the healthcare systems function through a high degree of delegation to self-governing bodies. And finally, Austria has a mixed model of healthcare financing, where 75% is financed by social insurance contributions and the state, to almost equal shares, and 25% comes from private sources such as PHI, OOPP, etc. (Hofmarcher M. M.,2013b).

Health on a federal level is overseen by the Austrian parliament, the *BMG* or Federal Ministry of Health, the *BMASK* or Federal Ministry of Labour, Social Affairs and Consumer Protection, and the social security institutions (Bundesministerium für Gesundheit, 2013; Zanon, 2016). Typically, legislation and enforcement are executed by the federal government, however several competencies are delegated to the *Länder* or to social security institutions. Basically, what this means is that the federal government determines the regulatory framework of the Austrian healthcare system and delegates statutory tasks to legally authorized stakeholders (Hofmarcher M. M., 2013a) such as the *Länder* and social insurance funds.

The *Länder* and local authorities play a key role in the establishment, implementation and also the supervision of the public health care system (Hofmarcher M. M., 2013b). Specific duties of the *Länder* include ensuring adequate hospital capacity, public health services, administration of social benefits and the provision of preventative services (Figure 7). In addition, the *Länder*

have departments geared to health promotion and health statistics, to name a few (Hofmarcher M. M., 2013b).

Figure 7 Division of Healthcare Competencies in Austria



The Political System

Austria is classified as being a premier presidential regime because its Chancellor has greater executive power than its President (Roper, 2002). These regime types are especially common in Eastern Europe and are also considered the most popular form of semipresidentialism (Roper, 2002). Researchers believe however that this classification is misleading as "Austrian presidents are only strong on paper" (Sartori 1997, pg 126) and the country should therefore be considered a parliamentary regime.

Shugart and Carey developed a way to measure premier presidential power dividing them into two dimensions: legislative and non-legislative power (Shugart and Carey, 1992). The legislative powers include veto power, decree authority, reserved policy areas, budgetary powers and the ability to propose referenda. The non-legislative powers of a president include cabinet formation and dismissal, censure and dissolution of parliament. The measurement methods for premier presidential regimes were implemented for the case of Austria, among other European countries (Roper, 2002; Shugart and Carey, 1992).

According to these measurements, the Austrian president has no legislative powers; little say in cabinet formation; and a very strong impact on the dissolution of parliament. This shows that amongst all the countries that have popularly elected presidents, Austria along with Bulgaria and Romania are amongst the weakest in the European Union. The significant strength of the Austrian President is in his ability to revoke the formation of government.

The Austrian Constitutional Court (*Vervassungsgerichtshof*) is made up of a President, a Vice-President, twelve members and six substitutes. In Austria, all constitutional judges are completely independent and should not make decisions based on party politics once they take on their appointed role. The appointment of constitutional judges is however a political decision. All Justices are appointed by the President of Austria. The federal government along with the two chambers of the federal parliament (National and Federal Council), however, makes the recommendations to the President (Cole, 1959). The Justices remain in office until they reach the age of 70, meaning they are appointed for life (Faber, 2009).

The competencies and tasks of the Austrian Constitutional Court can be summarized as follows, in order of importance (Faber, 2009):

- the infringement of fundamental rights by an administrative ruling (Art. 144

- B-VG);
- the constitutionality of statutes (Art. 140 B-VG);
- the legality of administrative regulations (Art. 139 B-VG);
- electoral disputes, in particular challenges to elections to the popular
- representative bodies such as the National Council (Art. 141 B-VG)
- rules on conflicts of jurisdiction between courts and administrative bodies (Art. 138 para. 1 B-VG)
- determines the distribution of powers between the Federation and the *Länder* (Art. 138 para. 2 B-VG)
- conducts impeachment trials against the highest state officers for violation of the law in the conduct of their office (Art. 142 and 143 B-VG)

The power of the Austrian Constitutional Court comes from its ability to solely review statues and repeal them. In addition, the Court can review every administrative decision. Judicial review must comply with all provisions of the constitutional law especially those found within the European Convention of Human Rights (Faber, 2009).

Since its re-establishment after WWII in 1946, the powers of the court expanded. In 1964, for example, the court was given the additional power to review the lawfulness of treaties. With an amendment in 1975 the provisions governing the review of laws and regulations was harmonized and the number of applicants entitled to file such a review was increased (Verfassungsgerichtshof Österreich, n.d.). Many smaller revisions and amendments followed and can be seen on the Constitutional Court of Austria's homepage. The most recent innovation was enforced in 2015 making it so that all courts of law have the right to challenge the

constitutionality of laws before the Constitutional Court (Verfassungsgerichtshof Österreich, n.d.).

This is relevant because many FPÖ policy proposals were enforced only to be later overturned by the Austrian Constitutional Court. The power of this court can be seen in the fact that it has continuously denied politicians the ability to pass unconstitutional laws. For example, in 2002 the then FPÖ Minister of Interior issued a directive withdrawing state support for all asylum seekers besides Afghanis and Iraqis (Albertazzi and Mueller, 2013). This was withdrawn as it was found unconstitutional by the Austrian High Court due to its breach of fundamental human rights. The same thing happened when the attempt was made to withdraw government support from all asylum seekers accepting help from NGOs (Albertazzi and Mueller, 2013). In 2003, again during the FPÖ participation in national government, a new asylum law restricted the appeals process for migrants; this was also struck down by the Austrian Constitutional Court (Akkerman and De Lange, 2012). Most recently, the Court declared the ban on wearing religious head coverings in schools, implemented by the previous ÖVP/FPÖ government, as unconstitutional.

Parliament in Austria is made up of two houses responsible for passing bills into law. The national council (*Nationalrat*), commonly referred to as the lower house, is the constitutionally more powerful of the two houses and houses the federal legislative authority in Austria. The federal council (Bundesrat) is the upper house and represents the nine Länder on a federal level. The 183 members of the National Council are elected by national popular vote for five years and whereas the 61 members of the Federal Council are elected according to proportional representation by each of the state legislatures (*Landtage*) for five to six years. This implies that the makeup of the Federal Council is subject to change after each state election.

In order for bills to become laws in Austria the bill must first pass through the lower house and then be approved by the upper house. However, if the upper house does not approve the bill, it can go back to the lower house and can be voted on again. If it is passed in the lower house a second time the bill, simply becomes a law without the approval of the upper house. There are however three exceptions to this scenario:

- Constitutional laws or regulations limiting the competencies of the federal states
- Laws relating to the rights of the Federal Council itself
- Treaties concerning the jurisdiction of the federal states.

In general, the lower house is significantly more important and powerful than the upper one, which is why its makeup will be the focus within this dissertation. Only the National Council majority will be considered given that the Federal Council has significantly less power and really only has a say when it comes to decisions made about the Länder. In order to hold the majority in the National Council and thereby be able to form a governmental coalition, parties need at least 96 of the 183 seats. A National Council majority is necessary in order for a governing coalition to form, thus, I will, go into some detail as to the nuances of the various majorities. These details can be found in Appendix B. Before starting with the national case, it is important to discuss the meaning of the party book economy in Austria as this is a reoccurring theme throughout the Austrian cases

Party Book Economy

Party book economy, or *Parteibuchwirtschaft,* as it is known in the German speaking realm, occurs when positions in public service and in business enterprises under political party influence are allocated. This can also refer to the allocation of material goods, services or ideal

values such as medals or honors based on party membership (or the possession of a party book). Essentially party book management ignores the factual criteria typically applied to award processes, thereby making it a form very closely related to political corruption. This is especially the case when it comes to filling public positions in schools, courts and audit courts. Politicians make personnel decisions according to proportional representation and political power calculations (expanding their influence or granting favors for friends) (Von Arnim, 2000).

In Austria, the ÖVP and SPÖ were the major political players for decades and thus split the control of courts, banks, schools, etc. between themselves (proportional representation). When the FPÖ entered the political scene in in the early 1980's, stopping the proportional representation and the party book economy was one of its main goals (Interviewee 1.3 Politician). For more information see (Schmidt, 2010).

The dynamics surrounding the concept of party book economy is not only partly responsible for the FPÖ's rise to power, but it also helps to explain why clientelism, of which it is a form, runs rampant within Austrian politics. While the FPÖ believed that the party book economy needed to be stopped, they certainly were not opposed to engage in clientelism (which is simply the exchange of goods or services for political support, without needing to belong to a certain party). As the following section as well as the next chapter will show, the FPÖ wanted to put an end to the party book economy so that they could also begin to influence the political structures within the country.

Austria: The National Case

The Federal Republic of Austria, located in the heart of Europe, boarded by Switzerland, Germany, Italy, Hungary, the Czech Republic, Slovenia and Slovakia has had a long-standing history of

being governed by a "Grand Coalition" made up of the conservative Austrian People's Party (ÖVP) and the Social Democratic Party (SPÖ). In fact, there were only a handful of years where there was not a grand coalition on the federal level[15], which is to say that these two parties dominated much of the post-war government. The other party that found itself in government three times was the Austria's Freedom Party (FPÖ). Today this party is considered to be one of the most successful Populist Radical Right (PRR) parties in Europe (Ennser-Jedenastik, 2016), but that was not always the case.

The FPÖ's first years in government as a PRR party (2000-2005) were marked by internal arguments and scandals wherein their policies, mostly social, generally took the back seat. By their third round in a governmental coalition (2017-2019), the FPÖ was much better prepared and able to implement (with the support of the new ÖVP) many pivotal health and social policies.

History of the FPÖ

The Freedom Party was founded in 1956 as a successor party to the Federation of Independents (VdU) by former national socialist Anton Reinthaller as an alternative to the red-black coalition governments of the SPÖ and ÖVP (Ellinas, 2010). The party was formed by both an economically liberal, i.e., "doctors, lawyers and also business owners that were turned off by the clerical ÖVP – mostly people that weren't Catholics" (Interviewee 1.2 Political Scientist), and a nationalist wing. These diverging interests often made the creation of clear political strategies difficult seeing as the former was interested in free enterprise and the preservation of individual

[15] In 1966 the ÖVP was in government alone. Between 190 and 1979 the SPÖ was in government alone. From 1983 until 1986 the SPÖ formed a coalition with the FPÖ. From 2002 until 2006 the ÖVP was in a governmental coalition with the FPÖ/BZO. In 2017 until 2019 the ÖVP formed a coalition with the FPÖ and in 2019 the ÖVP joined forces with the Greens.

liberties while the latter found its hold in the former Nazi philosophies. By 1958, upon the death of Reinthaller, Fredrich Peter took over the party and led it towards increased ties with the SPÖ. Under Norbert Steeger, "all the German nationals were pushed back" (Interviewee 1.2 Political Scientist), essentially removing them from the party and thereby allowing the FPÖ to pursue more of its liberal winged strategies. This strategy led to the FPÖ's first stint in national government in 1983 as the SPÖ's junior coalition partner. The relationship was short-lived as by 1986 after just three years in a crisis filled coalition Steeger lost support within his party and was replaced by the charismatic Jörg Haider.

> *Haider got elected by the nationalist faction of the FPÖ (only narrowly won over Steger) and thereby essentially sold himself to the nationalists, just like Strache did in order to get rid of Haider. The problem is that you can't get rid of the nationalists* (Interviewee 1.3 Politician).

Haider brought with him neo-Nazi tendencies that appealed to the parties conservative nationalists, an oratory gift that united him with his populous and an authoritarian grip that held together his party marking the FPÖ's turn to the PRR party family (Ennser-Jedenastik, 2016). Haider "restructured the party similar to other PRR parties across Europe as the party of the "little man" – these blue-collar workers" (Interviewee 1.2 Political Scientist). Under Haider the FPÖ achieved great success in both national and provincial elections and was finally seen as a viable alternative to the ÖVP and SPÖ (Figure 1). Haider began by

> *critiquing the elites – those up there they don't understand you. He called Vranitsky (former Cancellor of Austria – SPÖ) a "Nadelstreifsozialist" (pin-striped socialist) because of course this identification with the director of a bank and "Nadelstreif" (pinstriped) supporting the interest of the industry workers or the simple people this contrast is something Haider consistently tried to very visually present to people – through such terms. This upset Vranitsky terribly because he actually never saw himself like that* (Interviewee 1.2 Political Scientist).

By focusing his anger on the elites (the SPÖ at the time), Haider was able to unite

> *communists, socialists and Social Democrats and bring them onto his side. This wasn't a sole achievement on his part rather we can see these changes everywhere because of the modernization processes. There are groups that aren't able to cope with the change – we call these people in political science the modernization losers – and even then in the 80s, with the beginning of globalization – computers came, the borders opened, the EU developed – and that was a time where a lot of people, especially those that were less educated, felt threated by the immigrants and these are exactly the people that he was able to get on his side* (Interviewee 1.2 Political Scientist).

As a result, Haider's most popular political goal evolved into cutting down the number of foreigners allowed to live in the country. In 1991, he was able to pass a law stating that no more than 10% of the country's workforce could be made up of foreign workers[16]. This anti-foreigner sentiment is what would lead to increased tensions between the liberal and conservative factions of the party, resulting in the liberal faction leaving to form their own party in 1993.

From Welfare Populism to Welfare Chauvinism

The Haider period of the FPÖ (1986 to 2005) followed two main goals: 1) breaking the SPÖ/ÖVP dominance within the Austrian political party system and 2) Solidifying the FPÖ as a votable party fit to take part in a government coalition. The first point was a success as the SPÖ and ÖVP parties were forced to broaden their political party spectrum. The second point turned out to be more problematic for the party ultimately resulting in a new party leader and a complete rebranding of the FPÖ.

[16] This was reduced to 9% in 1993 under the Resident Alien Law.

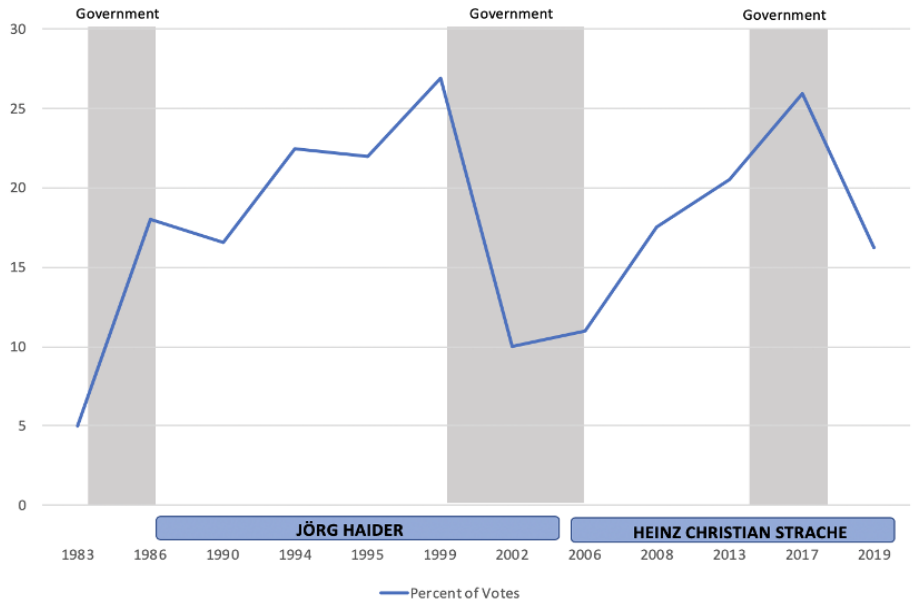
The FPÖ under Haider marked the party's turn from liberal to PRR (Bailer and Neugebauer, 1998). This was not only made visible through party members extreme right and neo-Nazi sympathies, but also through Haider's policies which offered simple solutions to complex problems. Haider presented his party as a new "workers party" wherein he sought to 1) decrease the power of the bureaucracy (trade unions, institutional structures, SPÖ), which he accomplished by passing the Pension Reform in 2000 wherein the Social Partners role was significantly decreased (Schludi, 2005; Talos and Kittel, 2001) 2) increase welfare benefits for the average worker whilst trying to simultaneously reduce these same benefits for bureaucrats[17] and immigrants (Hacklerregelung in Ennser-Jedenastik, 2016). In essence these were fairly contradictory goals. On the one hand, presumably wanting to decrease the generosity of the welfare system for bureaucrats by first and foremost removing their overwhelming influence on welfare policies while on the other increasing welfare benefits for the native working class. The policies passed during the FPÖs time in government under the leadership of Haider however resulted in benefit cuts for all leading to a loss in support for the FPÖ in 2000 (see Figure 8). So, what started out to be an engagement towards welfare populistic policies quickly turned to liberal chauvinistic ones. The impact that Haider left on Austrian politics, however, was great:

> *Although Haider as a person was always fervently sidelined, his content was not. The ÖVP/SPÖ coalition adapted many of his claims within the big coalition. Ex. Ausländer Volksbegehren (foreigner referendum) – everything was implemented: restrictive immigration, longer proceedings to become a citizen and all these things. Thematically, Haider quickly took control, but was personally always excluded* (Interviewee 1.2 Political Scientist).

[17] Attacks against bureaucratic privileges stopped once the FPÖ entered government (Ennser-Jedenastik, 2016).

So, while many of Haider's welfare chauvinistic ideas did not come to fruition during his leadership of the FPÖ, they did become part of the ÖVP/SPÖ party programs after his death.

Figure 8 FPÖ vote share at parliamentary elections 1983-2019



Source: Adapted from (Ennser-Jedenastik, 2016).

Following the FPÖs stint in government that led to a massive decrease in support, the FPÖ went in yet another direction under the leadership of Heinz Christian Strache. When Strache took over the party in 2006 he rebranded it as "die Soziale Heimatpartei" (the social homeland party) (Austrian Press Agency, 2005), thereby increasing its anti-immigrant, anti-Islam and pro welfare state messaging. This approach, known as welfare chauvinism, emphasizes generous welfare benefits for 'the people' and reduced benefits for "foreigners" (Falkenbach and Greer, 2018b; Mudde and Kaltwasser, 2017), which found great appeal with the socially disadvantaged native population (Ennser-Jedenastik, 2016). Whereas Haider's main policy points were immigration and pension reforms, under Strache the FPÖ made immigration their core issue while finding a moderate tone on socio-economic issues. This change in both leadership and policy focus paid off

as the party under Strache began recovering, reaching former heights by 2017 (Figure 8). The FPÖ under Strache was exceptionally successful until the 2019 "Ibiza affair"[18] that led to a dismissal of the ÖVP/FPÖ government and the removal of Strache from the party. Since that point the FPÖ has been struggling to find a charismatic leader to turn the party's luck around at the polls.

The FPÖ and their Social Policies

Haider and Strache had several things in common: Charisma[19], dedicated followers and a drive to implement strict immigration policies to limit the number of foreigners residing in Austria.

One of Haider's greatest accomplishments in this realm was maintaining one of the most restrictive regimes on family reunions for foreigners (Heinisch and Hauser, 2016), consistent with his aversion to European integration. Strache's greatest anti-immigrant feat was the passage of the Family Equalization Law, detailed below. Among their differences, however, was the way in which they pursued social policies.

Haider 2000-2005

Surprisingly, when the FPÖ was asked to join the ÖVP as junior partner in the 2000 governmental coalition, Jörg Haider, the head of the party at the time, opted to stay in Carinthia as governor saying that he would only go to Vienna as Chancellor (Badzic, 2008). Instead, Susanne Riess-

[18] A 2017 video was released to the press in the Spring of 2019 showing Austrian vice chancellor, Heinz-Christian Strache, discussing with a woman that he believed to be the niece of a Russian oligarch. In the video Strache promised the woman public contracts in exchange for campaign support. Upon release Strache and the entire FPÖ team stepped down and Chancellor Kurz called for snap elections (Oltermann 2019).

[19] "Although Haider was able to speak to these people more than Strache because he was seen as a legitimate intellectual person, and it is generally known that Strache does not have that quality. Which can be seen in the difference of appearance. Haider came to the Ash Wednesday meeting in a pin stripe suit, then he talked at a bank, at night he was at a firefighter party and the next day he was at some sport party, he always had four changes of clothes in his car, and he was able to speak to everyone. Strache was always the same, at the end he became a bit snobby" (Interviewee 1.3 Politician).

Passer assumed the role of vice chancellor for the FPÖ until 2002 when she was replaced by Herbert Haupt. Although Haider did not take the position of vice chancellor, a move that many argue weakened the party (Austrian Press Agency, 2003), he did still try to assume control of the ongoings in Vienna (Austrian Press Agency, 2004a). Thus, although Haider was not vice chancellor in the national governmental coalition, he was still head of the FPÖ and very much controlled the party's direction.

As previously mentioned, the FPÖ under Haider would have ideally followed a welfare populistic path with regards to social policy, however, his coalition partner prevented this pushing him more onto a typical conservative one wherein cuts were made across the board not regarding "in" or "out" groups. This can be seen through the pension reform passed in 2000 and fully implemented by 2002. All FPÖ manifestos between 1986 and 1999 called for cuts to or the abolition of politicians' pension privileges or severance rights (Ennser-Jedenastik, 2016) whereas the ÖVP wanted to abolish the early retirement scheme, increase financial penalties for each gap year in contributions, lower the conversion rate for each year of contribution and substantially change how pensions were calculated (Afonso, 2014). In an effort to reach a zero deficit three years ahead of schedule (politically important for both parties), the compromise that ensued was an increase in the early retirement age of 1.5 years for both men and women, an increase in the statutory age of retirement for public employees, increased penalties for people retiring sooner than the statutory age of 60 for women and 65 for men, and it completely abolished all newly granted widows' pensions for retirees, whose own pension entitlements exceed a certain income limit (Schuldi, 2005). Consistent with the FPÖ's desire to dismantle the traditional social partnership system (Greer and Falkenbach, 2017) from which it was excluded, the FPÖ notably tried to condition its support for the pension reform on a 40% cut in the mandatory contributions

of individuals to the Austrian Chamber of Labour, thereby decreasing the union's institutional influence and satisfying a promise to its core voters, but the ÖVP rejected the demand. The result was that the FPÖ essentially went along with the ÖVP's Conservative plans, garnering them much backlash from their core voters (this may have also influenced the drop in voter support during this period - Figure 1).

The social policies passed during the FPÖs governmental stay under Haider's leadership from afar can be summarized as having been primarily influenced by the ÖVP as they were generally in line with conservative policy changes in other countries (Heinisch, 2003a), but they also served to weaken institutional networks and break ties with the traditional corporatist structures (Röth et al., 2017). The radical and oft populistic tendencies that shone through every once in a while, were eloquently contained by the ÖVP (or the constitutional court) and therefore not particularly noticeable in implementation. In essence, when in government during this time, the FPÖ helped to enact a series of classical conservative reforms and fiscal measures that ended up being felt most acutely by the very same people the party had wanted to protect - workers (Heinisch, 2003a). This, along with the split of the FPÖ,[20] led to a radical decline in the polls (see Figure 1) until Heinz Christian Strache's leadership coupled with Haider's death gave the party a new wind.

Strache 2017-2019

[20] In 2005, Haider split with the FPÖ to form the BZÖ which immediately took the place of the FPÖ in the coalition with the ÖVP. "There were no big differences between the FPÖ and the BZÖ as it was simply an association name change" (Interviewee 1.3 Politician).

The former Health and Social Minister, Beate Hartinger-Klein (FPÖ) summarized the FPÖ agenda during their 2017-2019 governmental period as "new" and advocated for "social justice" (Austrian Parliament, 2019b). This fit well with the nativist stance the "new" ÖVP (Schultheis, 2017), under chancellor Kurz, was taking (Gady, 2017). Both the ÖVP and FPÖ supported cuts for foreigners, whereby refugees marked the starting point for broader cuts sealing their government program as politically neoliberalistic and welfare chauvinistic (Becker, 2018). During their two year stay in government several different social policies were passed, three of which were distinctly welfare chauvinistic in practice.

Beginning with the Family Bonus Plus regulation (Austrian Parliament, 2018c) every family would receive a tax credit of €1500 per child per year up until the children's 18th birthday thereby reducing that tax burden of parents. Upon first glance this seems to be a very generous, pro-welfare move. However, upon closer examination the tax credit applies only to families whose children live in Austria or EU countries (including Switzerland). This regulation was heavily criticized by the opposition because it lacked differentiation between the various socio-economic groups implying that the motivation for the reform was a cultural one and not redistributive (Austrian Parliament, 2018a) seeing as families from more Eastern European countries with their proportionately larger families would get less. In addition, the credit would be less if the child lives in an Eastern European country[21] (Seidl, 2018), increasing the welfare chauvinistic style of the reform.

[21] Childcare money is matched to the amount the child would receive in the country where it resides. So, while a 0-2-year-old Austrian child would €114, a 0-2 child living in Bulgaria whose parents work in Austria would only receive €51,30. Similarly, a 0-2 child living in Luxembourg whose parents work in Austria would receive €134,52.

In November of 2018, Health and Social Minister Hartinger-Klein (FPÖ) proposed the new minimum income law which would standardize the minimum income across the country while also tightening eligibility rules, promoting general cost efficiency and decreasing the dumping "of immigration into the Austrian social system" (Austrian Parliament, 2019a). The law was proposed, in particular to increase the fairness for Austrians wherein Chancellor Kurz argued that "there are more minimum income recipients than the entire population of Burgenland", and that "every 2nd person that receives this money is not an Austrian citizen" (ORF, 2019). The proposal stated that a single person would receive €863 per month, which is the same as in the current law. The difference is, if that single person "does not speak German well or at least speak English, that amount would be reduced to €563 per month" (Interviewee 1.6 health and welfare expert). In addition, the proposal sees that families with children would no longer receive the same amount of money per child. Instead, "after the 2nd child the amount received per subsequent child would decrease substantially" (Interviewee 1.6 health and welfare expert). This additional condition targets, in particular, families with many children - i.e., migrant families. Excluded from any benefits according to the legislation are criminal offenders, foreigners without residence permit as well as asylum seekers – in short, minority groups at the bottom of the social hierarchy according to the PRR. Health and Social Minister Hartinger-Klein (FPÖ) summed up the proposal nicely: "Fairness for Austrians, others have to wait" (Krutzler, 2018). While the proposal was never implemented due to the governments premature termination resulting from the Ibiza scandal, this is certainly an example of welfare chauvinism and clearly "shows which groups the FPÖ is in favor of supporting with the guaranteed minimum income and which it wants to exclude" (Interviewee 1.4 Politician).

The last social policy change, the Family Equalization Law Amendment, was implemented on January 1st 2019 wherein child support for parents working in Austria whose children live outside of the country would be adjusted to the child support standards of the country in which the child resides (Austrian Parliament, 2018b). This implied that Austrian employees whose children reside in Eastern and South-Eastern European EU countries would receive reduced benefits. The desired effect of the policy was to prevent the abuse of welfare payments by other EU nationals that live in Austria and would be, under European law, eligible for social security provisions for their children, even if those children live in another country. The hidden agenda herein was to make Austria less attractive for economic migrants. This amendment could very well be categorized as being welfare chauvinistic seeing as the government wanted to prevent the welfare state from being seen as an instrument catering to those "undeserving of assistance", i.e., economic migrants.

While the FPÖ ran on and promised welfare populistic social policies in the late 90's, what resulted were ÖVP led conservative policies that ended up hurting the FPÖ voter base resulting in decreased support for the party by the early 2000s. The FPÖ government under Strache between 2017 and 2019 generally advocated for, and at times was even able to pass welfare chauvinistic social policies with the help of the new ÖVP. The reason that the FPÖ under Strache was able to play more towards its own agenda of welfare chauvinism was because his coalition partner, the "new" ÖVP under Kurz, was not only seen as being more right leaning (Austrian Press Agency, 2017) than his predecessors (i.e. Schüssel), but also because the party moved away from its values surrounding Catholicism and tradition and more towards a value

base that was situationally elastic and unable to be clearly defined[22]. In fact, many political scientists and commentators feel that the new ÖVP is taking on the role of the FPÖ (Bartlau, 2019; Bodlos and Plescia, 2018; Lackner, 2017; Liebhart, 2019; Löffler, 2020). These characteristics combined with the FPÖ's Austria first mentality in the health and social sectors (Interviewee 1.3) made the governing coalition that formed between the new ÖVP and the FPÖ particularly precarious seeing as both parties favored welfare chauvinistic policies accompanying an anti-immigrant political discourse.

The FPÖ's Role in Shaping Health Policies

In two of the three times that the FPÖ participated in coalition governments they controlled the health ministry (2000 to 2003 and 2017 to 2019). The 2000 ÖVP-FPÖ coalition did not introduce deep systemic changes to the health care system; however, smaller regulations, such as a partial renunciation from the free co-insurance for couples without children or a new law to raise private patient contributions were introduced (Tálos, E., & Obinger, 2019; Unterthurner, 2007). As part of the national government, the FPÖ has also contributed to major structural reforms, which began to take shape between 2000 and 2003 and were consolidated in the second ÖVP-FPÖ coalition between 2017 and 2019 (Hofmarcher, 2019). What is particularly interesting in light of these structural reforms is that while the FPÖ/ÖVP governments in both 2000 and again in 2017 aimed at reconstructing the social insurances, the SPÖ/ÖVP government between 2007 and 2017 attempted to strengthen the coordination and cooperation between the different actors within Austrian health care system (Hofmarcher, 2019). Furthermore, the FPÖ positioned itself as a harsh

[22] Interviewee 1.11 Austrian Public Health Expert.

opponent of tobacco regulations and pushed to overturn a planned smoking ban in bars and restaurants in 2018.

Table 4.1 Overview of Key FPÖ Health Policies

PRR Health Policy	**Implemented**	**Coalition Partner**	**Clientelistic nature**	**Outcome / Comments**	**Classification**
Overturning the smoking ban of 2017	Smoking ban was overturned in March 2018	New ÖVP	No	The ÖVP/FPÖ Government was dismissed Spring 2019, smoking ban was reinstated in November 2019	Anti-Science
Financing reform of private hospitals (2018)	2018	New ÖVP	Yes, the FPÖ party received payments from the private hospitals it helped by passing the new law	Private hospital clinics receive an additional €73 million in the next few years via cost reimbursements from the social insurance contributions of workers	Welfare Chauvinist

Health Insurance Merger 2019	21 insurances were merged into 5 in 2020	New ÖVP	Yes – many former SPÖ health positions were now given to FPÖ/ÖVP	This unification promised to bring €1billion in savings to be used to serve the Austria people. Instead, it brought millions in losses (Egyed, 2020), even more with Corona (Austrian Press Agency, 2020a)	Conservative / Liberal chauvinism
New electronic health insurance card (2019)	2019-2022	New ÖVP	No	All e-cards are required to have a photo identification on the card by 2022 costing about €18 million	Welfare Chauvinism

The Social Insurance Merger

The reshaping of the social insurance system was a key target in the 2017-2019 ÖVP/FPÖ government. Although this merger was something that the ÖVP readily agreed to, it was a political decision originally brought forth by Jörg Haider in 1988 (Neubauer, 2019). Haider's reasoning behind the merger was political, namely destroying the SPÖ stronghold and replacing several of the SPÖ's officials with his own. While some politicians posit his goal was "cost-

saving (as the 21 different health insurances cost too much and were too bureaucratic to manage) and more so to be able to have more control over the officials[23]" (Interviewee 1.3 Politician) others assert that the "FPÖ always followed the big goal of destroying the structures of the social insurance system" (Interviewee 1.4 Politician), put differently, "Haider's biggest argument for the merger was to break up this red black Proporz system (proportional representation)" (Interviewee 1.8 Politician).

In December 2018, the Austrian parliament adopted the Social Insurance Organizational Act (SV-OG), which merged the preexisting 21 social insurance institutions into only five institutions. These five institutions are now represented by an umbrella organization (Dachverband), instead of the former "Federation of Social Insurance Institutions". Despite the fact that the European Commission approved the reduction of social insurance companies in Austria, the implementation and consequences of this massive structural change is worth a closer look.

On the homepage of the Austrian Federal Ministry for Health, the reform is described as "ensuring an efficient and modern social insurance system, which is closer to ordinary people." (Austrian Ministry of Social Affairs Health Care and Consumer Protection, 2020). To achieve this goal, the plan was to reduce costs through a merger. Thus, the nine regional insurance institutions for privately employed citizens were merged into one national "Austrian" health insurance fund

[23] "After WWII, Austria had the Christian Democrats, Social Democrats, Communists and the Association of the Independents – all other parties were prohibited. Up until Haider took over the FPÖ, everything was divided in Austria between red and black. There were red banks and black banks, red social insurance institutions, black social insurance institutions, red car clubs and black car clubs. So, everything was split, and these masses of officials were tied to each party. No other party could place officials because all the positions were already taken" (Interviewee 1.3 Politician).

(Österreichische Gesundheitskasse, ÖGK). In addition, the Insurance Institution for Public-Sector Employees (BVA) and the insurance institution for Railway and Mining workers (VAEB) were merged into the Public-Sector Employees, Railways and Mining (BVAEB) and finally, the insurance institutions for trade and industry and for farmers were merged into a common insurance institution for the self-employed (SVS).

The most criticized components of this reform were a) the proportional representation of employer and employee organizations in the newly merged insurance institutions b) the emergence of a three-tiered medical system (privately employed, state employed and self-employed citizens) depending on what type of profession you work in and c) the reduction of administrative costs (Hofmarcher, 2019) by 1 billion Euros (Jungwirth, 2018), in line with Haider's vision 30 years prior. The critical fact was, however that the reform was projected to cost more to execute than it would save.

This reform created a proportional representation system within the newly merged social insurance institutions leading to a further power shift in favor of employer organizations and a degradation of the role of labor unions (Hofmarcher, 2019).

> *The FPÖ sought to change the governance model of the social insurances at its very core. Before the 2000-2003 ÖVP/FPÖ government, we had a worker's majority in the governance of the social insurance institution – meaning 2/3 representation came from trade unions and 1/3 came from employers. The FPÖ wanted to change this to a parity, OK? And in 2000 they did not succeed in making any changes. Immediately after they came to power again in 2017, the FPÖ took up this issue again and succeeded in really transcending this idea of parity of employers and employees on all levels of social insurance and not only on the executive level* (Interviewee 1.14 Health Economics Expert & Advisor).

Furthermore, even though the reform targeted a merger of health insurance institutions, the differentiation between professions remains an integral part of the Austrian social insurance

system. Consequently, existing inequalities were not resolved because the reimbursement is still different depending on which institution citizens are assigned to. One of the main reasons the ÖVP helped the FPÖ push this reform was to change the "governance model towards supporting more liberal economic interests" (Interviewee 1.14 Health Economics Expert & Advisor) however, "the savings that it was supposed to produce was just recently negated through a report meaning that it will cost a lot more than it will save" (Interviewee 1.4 Politician). In fact, "nobody has been able to present this savings potential in a credible way" (Interviewee 1.5 Politician).

The ÖVP wanted to reduce health expenditures through the merger, while the FPÖ wanted to buy themselves into more high-level positions within the social insurance system. Through the combination of their interests what they achieved was the end of the majority representation within the social insurances thereby weakening the trade unions, increased high-level positions for the FPÖ within the system thereby getting rid of many SPÖ officials and huge merger costs due to increased bureaucracy instead of the savings promised by the ÖVP. As to whether the merger idea was ÖVP or FPÖ driven, this can be debated:

> *I would think it was an FPÖ idea. If I remember correctly, already under Haider, one of the biggest demands was the merger of the over 20 different health insurances and thus I think that the driver in this reform was the FPÖ. But the other, and this is where the ÖVP enters the game, was a wonderful chance to expand their political power. To change things (structures and positions) completely, i.e. To construct the self-administration in such a way that the influence of businesses and employers expanded greatly compared to what it previously was. So, the demand by the FPÖ that they want to take on the red/black juggernaut, which fit into the plans of the ÖVP as they saw it as an opportunity to expand their power by being able to put their people (new ÖVP-turquoise) in positions of power (within the healthcare area – previously a "red"/SPÖ stronghold)* (Interviewee 1.8 Politician).

One thing however remains to be the case "the population still has a social insurance system and there are very few that are excluded from that and when one changes the structure of the social insurances there will still be no change in the fact that the people will be insured" (Interviewee 1.1 Health Expert / Politician). However, "in several years we will see that it cost the system a lot of money which will result in less services for the patients. For me this is neo-liberalism pure and goes into the direction that debt gets nationalized and profit get privatized. And here the ÖVP and FPÖ are on the same ideological spectrum." (Interviewee 1.15 Politician).

The predicted result of the merger according to countless interviews with politicians and healthcare professionals is an increase in bureaucracy leading to an increase in costs and an eventual decrease in health care services covered by the social insurances. The merger, as reported by the LSE in 2017, should have addressed the broader structural problems of the Austrian social insurance and the health system in general (London School of Economics, 2017). Some of the most important points laid out by the LSE report, commissioned by the SPÖ/ÖVP government in 2016, were adjusting the risk between the different health insurance providers and the nine provinces; rethinking the centralized planning for budget and services; and harmonizing the quality of services provided in the nine provinces. However, the result, ended up concentrating on institutional issues in the narrowest of senses and does not come close to solving the major structural problems of the Austrian social insurance, most specifically the health insurance system.

In addition, because the merger created three different health insurances, each directed towards a different working class group (bureaucrats, self-employed and employed) we will not see an equitable decrease in services (Fink, 2018). Instead, I predict that the employed coupled

with the migrants will likely be subjected to the biggest cuts thereby bypassing a two-tiered healthcare system and moving right up to a three-tiered healthcare system.

A Separate Social Insurance for Migrants

In 2017, when the ÖVP and FPÖ were speaking about the merger of the 21 health insurances, the FPÖ wanted to create a 6th insurance just for migrants. The idea was to establish a parallel health insurance for non-EU nationals living in Austria who would receive less services than others, with more out-of-pocket-payments. This information was never released to the public, nor was it ever discussed in any media, so people outside of the political realm did not know about these plans. Interviews confirm this fact:

> *Yes, I have heard about this (the creation of a parallel insurance for migrants), but I don't take this very seriously. I have heard about this, but I have no further information. It is consistent with the FPÖ because if you think about the redistribution of risks and what they have done with the merger. They have pooled the higher risks and pooled the low risks. So again, we do not have risk equity process which would be useful. Creating a migrant insurance is another risk layer. Now they are at least in the pool of the 7 million insured by the ÖGK, but they (ÖKG insured) themselves have already higher risks compared to the smaller merged insurances because you have in those smaller funds you have the self-employed, officials, civil servants, and they do not have many risks compared with those in the ÖGK* (Interviewee 1.14 Health Economics Expert & Advisor).

> *I have heard about these plans for a parallel insurance more as a rumor. They were brought up in some speeches about the reform of the regional health insurance funds, […] that this foreigner insurance fund too, is still a dream of the FPÖ, and has been aggressively discussed [...]. I think many constitutional lawyers who still exist in the ÖVP have not gone that far. But there are tendencies there too (SPÖ politician with focus on integration)*[24].

[24] Interview taken from (Spahl and Falkenbach, 2021).

Naturally, this separate social insurance for migrants did not come to fruition, but it clearly demonstrates the FPÖs welfare chauvinistic intentions if they would not have been hindered by the institutions (Parliament) or their own coalition partner, as one assumes happened.

Private Hospitals Financing Fund

Another health policy decision that can be traced back to the FPÖ was the passage of a law that led to the financing reform of private hospitals. Private for-profit hospitals make up 20% of all the hospitals in the country (public hospitals make up 50%, religious orders and trusts 15% and insurance and pension funds 15%) (Sheshabalaya, 2010). Private hospitals are usually run by private operators and their capacities are typically larger than those of public hospitals. For the most part patients with private health insurance are treated in private hospitals. As far as financing is concerned, private for-profit hospitals receive compensation for the services they provide via the social insurance system if they belong to Prikraf (private hospital financing fund). Prikraf is financed through a lump sum contribution from the social insurance system, adjusted annually to the increased contribution rate (Bachner et al., 2018).

The FPÖ helped pass this aforementioned law for the benefit of private hospitals in exchange for financial support. As of 2018, the Prikraf was given an additional €15 million, representing an 11.5% increase, marking a shift towards strengthening private providers within the Austrian health care system (Fohringer, 2020).

> *When this PRIKRAF fund originated, it was a good move because it helped contain cost growth for the social health insurance. This was very important because we had double digit cost growth within the hospital sector prior to the budgeting of hospitals at the end of 1997* (Interviewee 1.14 Health Economics Expert & Advisor).

The initial Prikraf regulations were quite simple: 45% of the private hospitals in Austria can receive money from the Prikraf if they provide medically necessary services for the compulsorily

insured. Which hospitals are allowed to do this is determined by law; the hospitals that can get money out of this fund must be named in the law and who gets named is decided by the main health insurance association (ÖGK) and the professional association of healthcare companies ("Fachverband der Gesundheitsbetriebe"), following the principle of "self-administration."

What happened is that Walter Grubmüller, head of the private clinic in Währing approached his longtime friend Heinz-Christian Strache at the beginning of 2017 asking if the clinic could be added to the Prikraf. Text messages between the two confirm that Strache explicitly asked which law needed to change so that Grubmüllers clinic could be included. While the FPÖ initiated the deals, the ÖVP under previous finance Minister Löger and Chancellery Minister Blümel agreed to the deal.

When recently questioned about the case, now Finance Minister Blümel stated that the ÖVP had nothing to do with it: "The reform of the Prikraf and the admission of the Währing private clinic was due to Strache's insistence and falls under the competencies of the Ministry of Health (FPÖ). In essence, it was an implementation of the government program" (Schmid 2020). This has been proven false in court; the ÖVP were very much involved and benefited greatly from the reform, although it was instigated by the FPÖ. "I think it is amazing, how easily this happened. I mean discussions about this were really very minor. It is quite impressive that they got away with doing this" (Interviewee 1.14 Health Economics Expert & Advisor).

This reform is not only problematic because of its highly clientelistic components, but also because 70% of the additional money in the fund is paid for by the ÖGK (the Austria health insurance fund), who was not even informed of the deal until after the draft law to the ASVG. In addition, those insured through the ÖGK contribute a significant amount of money to the Prikraf fund, but they only use 50% of the beds, the rest are used by the self-employed and civil servants

(covered by a different insurance company) [25] (Fohringer, 2020). The FPÖ played the game of clientelism without thinking about which voters would be most impacted by the policies they pass, namely their own[26].

The New E-Card

The National Council decided that starting on 01.01.2020 all newly issued or exchanged e-cards (health insurance cards) for people over the age of 14, must depict a photo clearly showing the cardholder (Section 31a (8) ASVG). By 31.12.2023 all old e-cards must be exchanged for new e-cards with a photo. The introduction of the e-card with a photo was introduced and justified by the ÖVP/FPÖ government at the beginning of 2019 with the argument that one wanted to prevent misuse. Health and Social Minister Hartinger-Klein (FPÖ) stated: "The new e-Card can do everything - it brings security against misuse and security with regard to unique identification for the electronic health database ELGA" (FPÖ, 2019).

Despite lacking actual evidence as to the scope of the misuse, the FPÖ pushed for changing all e-cards in Austria to the new photo e-card, which former chairman of the umbrella organization of the Austrian social insurance agencies, Alexander Biach, estimated the cost to be about 18 million Euros (Kleine Zeitung, 2017). Before the implementation of the new law at the beginning of 2019, the FPÖ released a video wherein the laws intention became very clear (see Figure 9). The Austrian regulatory authority for broadcasting and audiovisual (KommAustria) decided that the video violated the Austrian law against discrimination (Austrian Press Agency, 2019) and was

[25] Interviewee 1.12 Austrian Public Health Expert.

[26] Considering that the FPÖ emerged into the political scene because of their desire to prevent the party book economy and subsequently clientelism, their involvement in this scandal was not readily accepted by their voters.

therefore quickly removed from the internet. Not only is the cost for reissuing e-cards exceptionally high, but the amount of money saved in terms of misuse is comparably low (Austrian Press Agency, 2020b).

Figure 9 FPÖ Video[27]

According to Chancellor Kurz, this "misuse" was "costing Austrian tax payers dearly" and "around 200 million Euros could be saved" (John, 2020). This argument was simply not factually based, in fact, the damages caused by e-card fraud as reported by the Viennese health insurance company, the largest health insurance company, in 2016 was only 9,935.74 euros and the Lower Austrian health insurance company reported only 4,863.76 euros in damages. All other health insurance companies in Austria reported no damage due to improper use of the e-card during this time (Egyed, 2018). In light of this fact, Chancellor Kurz, at this point already in coalition with the Green Party, called upon the Minister of Interior Karl Nehammer (ÖVP) in 2020 to put together a special police force to look into welfare fraud. The result was 11,5 million Euros in damages from e-card misuse (Schlager, 2020), a far cry from 200 million Euros.

[27] In the video released by the FPÖ, uninsured Ali, who appears to be a Muslim, wants to use health care services with the e-card of another person (his cousin Mustafa). Because of the newly introduced picture on the e-card, he fails to do so.

The Austrian Smoking Ban

The prevalence of smoking in Austria is among the highest in Europe. On average, around 25 percent of the Austrian population report to be daily smokers (European Social Survey, 2014). This is one of the highest scores in the EU (only Hungary has a higher prevalence of daily smokers). Furthermore, the smoking rate is particularly high among young people (Berger and Neuberger, 2020). One reason for this high rate might be the liberal smoking regulations. In fact, until recently, Austrian citizens were allowed to smoke in bars and restaurants, despite overwhelming scientific evidence that smoking bans in bars and restaurants were able to reduce smoking behavior and limit initial smoking habits among youth in particular (Johan P Mackenbach and McKee, 2013; Siegel et al., 2005). Despite this evidence, the Austrian road towards stricter tobacco regulations has been rocky (See Table 8). Some observers see close links between the tobacco industry and Austrian politics (Burki, 2018).

In 2015, the Austrian parliament, at this time dominated by the two traditional parties, the Social Democrats and the Conservative People's Party (ÖVP), adopted a general smoking ban in bars and restaurants, which was to come into effect by May 2018. There was, however, another election between the adoption of the ban and its actual enforcement. In 2017, the FPÖ joined the ÖVP in government wherein one of their campaign pledges was to scrap the scheduled smoking ban law (Burki, 2018). Even though the conservative coalition partner was not fond of this decision, it relented to the pressure of the FPÖ and voted to overturn the smoking ban. Media reports speculated that this was a political horse-trade, in which the FPÖ agreed to sign the EU-Canada Comprehensive Economic and Free Trade Agreement (CETA) in exchange (Neuberger, 2018).

The key arguments used by the FPÖ in overturning the smoking ban were framed in terms of a) individual freedoms (the ordinary people's right to smoke in their bars) and b) economic consequences (the survival of bar owners). The individual freedom framing followed the argument that bar and restaurant owners should be able to choose freely as to whether or not smoking should be allowed within their establishments. Furthermore, they argued that customers would be free to go to smoking or non-smoking bars based on their personal preferences. In this context, the FPÖ often spoke of the so-called "Zwangsverordnungen" or coercive regulations imposed by the government. The economic consequences frame identified a negative impact for bar and restaurant owners, especially for "small" bars, wherein regular customers that were used to smoking indoors would no longer frequent the bars.

Table 4.2 A rocky road of smoking regulations in Austria

Year	**Policy**
1974	Smoking ban in school buildings (with exceptions)
1993	Mother protection
1994	Smoking ban for bus drivers (while driving)
1995	Smoking ban with exceptions / employee protection law
2001	Smoke-free workplace regulation
2006	Smoking ban in school buildings
2007	Smoking ban in trains
2009	Smoking ban in restaurants and bars with many exceptions
2015	General smoking ban in bars and restaurants as of May 2018
2018	**Repeal of the 2015 general smoking ban**

2018	Smoking ban in schools (incl. school yards)
2019	Repeal of the repeal of the 2015 general smoking ban
2019	General smoking ban comes into effect as of November 1

The Role of the ÖVP

The Conservative center right Austria People's Party (ÖVP) played a significant, yet distinctive role each time the FPÖ was in government. In 2000, when the FPÖ under Haider was in government as the minority coalition partner, the ÖVP was described as being "very neo-liberal, influenced by catholic values and promoting somewhat of an achievement society" (Interviewee 1.10 Public Health Expert; Interviewee 1.11 Public Health Expert; Interviewee 1.12 Public Health Expert). In fact, this description held true for the ÖVP until Sebastian Kurz took over the ÖVP in 2017 changing not only the party's corporate design and color from the traditional black to turquoise but also its name "List Sebastian Kurz–the new ÖVP" (Bodlos and Plescia, 2018; Plescia et al., 2019). In addition, Kurz made ideological changes as well, largely renounced its pro-European and anti-sovereigntist positions (Heinisch et al., 2020) as well as dropping the parties strongly catholic values and adopting instead a PRR agenda implying a clear shift to the right and away from the center (Gady, 2017; Wodak, 2018). Politicians, political scientists and researchers alike draw parallels between Kurz and Haider stating that

> *Kurz did it smart in that he presents himself as a very eloquent, well-behaved son-in-law type. But in truth, if we analyze his political style, 90% is that of Haider. He didn't invent anything new; he also doesn't have the intellectual capacity to invent anything new, but he manages it well. It is enough if Mr. Kurz stands there, formulates it (policies) a bit more moderately than Haider did, and he will get 40%. And Haider would have gotten 40% today in Austria* (Interviewee 1.3 Politician).

Put in a more neutral, moderate tone, "Haider always gave the big promise that he will change this party membership structure, classical populist, one of the first, a great communicator and many believed him. We can probably see some parallels to Kurz that communicates this very similarly" (Interviewee 1.2 Political Scientist).

These changes in ÖVP leadership are crucial to consider when evaluating the policies initiated by the FPÖ given that the ÖVP was always the more powerful coalition partner during the FPÖs times in government. From 2000-2005 many of the FPÖ's policy proposals failed (health insurance merger, a 40% reduction in the compulsory levy for the chamber of labor within the pension reform and many other migration and integration reforms) because they were deemed too radical and not in line with the catholic and economic values of the ÖVPs agenda.

In 2017, however, when Sebastian Kurz won the election for the "new ÖVP", the parties agenda was much more in line with that of the FPÖ's (both the ÖVP and the FPÖ focused on immigration as an issue (Plescia et al., 2019)). With this common ground and shared tendency towards neoliberal and welfare chauvinist policy making (Interviewee 1.12 Public Health Expert) the FPÖ was able to get many of its policy initiatives passed.

Conclusion

The FPÖ influenced health outcomes via indirect (social) and direct (health) policy choices. Based on a wealth of research on the social determinants of health (Braveman and Gottlieb, 2014), I first looked at social policies. The analysis of the FPÖ's social policies indicated that the FPÖ moved from a populist welfare approach under the leadership of Haider to one based more on welfare chauvinism when Strache took over the party. The pension reform in 2000 can be seen as welfare populist in character as it not only broke the unions hold on pension reforms, but also increased

the retirement age for many bureaucrats. The reduction of the minimum income for foreigners or the discriminating "family bonus" could be interpreted as welfare chauvinist as the welfare benefits of natives were increased while simultaneously decreasing the benefits of foreigners. These social policies significantly impacted the health of the individual. Lengthening working careers is not beneficial to everyone, much depends on a person's health and more importantly their willingness to continue working (Ilmakunnas and Ilmakunnas, 2018). In addition, a lack of income severely impacts a person's participation in society and subsequently their ability to receive the necessary services (healthcare) (Marmot, 2002). These examples of FPÖ social policies depict a potential for increased inequalities not only within the social policy realm, but also spilling over into healthcare.

Next, I looked at how the FPÖ influenced health outcomes directly via health policy decisions. Bearing in mind that in health politics the "FPÖ wants to strengthen the influence of the government and weaken the institutions outside of the government that are also involved in healthcare decisions" (Interviewee 1.4 Politician), their policies can be divided into two categories: 1) structural reforms of the health system such as the social insurance merger and the introduction of a private hospital financing fund and 2) policy choices targeting behavioral outcomes, such as the introduction of new e-cards and the reversal of the smoking ban.

The structural health reforms took on welfare chauvinist and liberal chauvinist characteristics wherein the liberal chauvinist approach was more prominent, very likely due to the close involvement of the ÖVP. These structural reforms were very important because "they changed the color of who is in charge" (Interviewee 1.2 Political Scientist) thereby giving the FPÖ more influence within healthcare structures (Haider's initial goal in the 90's). The ultimate result of the merger was a breakdown of the SPÖ stronghold in all things health wherein the FPÖ and

the new ÖVP could now position key players within the newly created health insurance company ÖGK (resulting from the fusion of the nine regional health insurance companies).

Looking at the other structural reform initiated by the FPÖ, PRIKRAF, or the private hospital reform, we see just how prominent clientelism continues to be within the political realm. Accusations of clientelism were also geared towards the ÖVP implying that clientelism is not only a PRR problem, rather one that is deeply imbedded within the structures of the political system in Austria, as well as in other countries no doubt. This reform was not only problematic because of its highly clientelistic nature, but also because much of the money that is used to support the private hospitals is paid for by patients' contributions. In addition, those insured through the ÖGK contribute a significant amount of money to the PRIKRAF fund, but they only use 50% of the beds, the rest are used by the self-employed and civil servants (covered by a different insurance company) (Fohringer, 2020). While this reform can clearly be considered clientelistic, it also has a hidden welfare chauvinistic flair to it. The FPÖ, more often than not sells itself as a worker's party catering to those that see the brunt of globalization, however the FPÖ is also a party that caters to the *Burschenschaften* (traditional student fraternities), largely made up of wealthy extremely right leaning educated FPÖ voters. By modifying the PRIKRAF to include more private hospitals the FPÖ was catering to its much smaller electorate by increasing the welfare benefits of those that can afford private insurance on top of the mandate public insurance while potentially decreasing benefits for all non-privately insured Austrians covered by the ÖGK.

The reforms targeting individual behavior, however, can be classified as welfare chauvinist with regards to the e-card changes and anti-science with respect to the overturned smoking ban, increased corona measures and a general lack of support for vaccinations. While several of the health policy reforms passed were done so with the help of the ÖVP, the FPÖ distinguishes itself

from its conservative coalition partner by also putting forth policy decisions that sharply contrast scientific evidence. The most important example is the FPÖ's role in overturning the smoking ban which had been introduced by the former SPÖ-ÖVP coalition. Against overwhelming scientific evidence, the FPÖ portrayed itself as the protector of small business owners and ordinary people propagating individual choice over top-down regulations.

In summary, the FPÖ's policy choices incorporate both clear markers of well-known PRR characteristics as well as elements influenced by its conservative coalition partner. Favoritism towards the native, ordinary people and the systematic exclusion of foreigners from the eligibility of health and social services is the predominate FPÖ policy mantra. Examples can be found in the introduction of a photo-based e-card, the new minimum income law or the Family Bonus Plus regulation. Also, in line with conceptualizations of PRR parties is the liberal chauvinist approach coupled with anti-elitist sentiments, which became apparent in the structural reform of the health care system. The legitimization of this reform, which the ÖVP actively supported, was to create a system "closer to the ordinary people". Interestingly enough, however, it decreased the representation and thus the self-administrative power of the worker group, represented by established labor organizations. The short term "aims" appeared to decrease bureaucratic costs and relieve the SPÖ of their monopoly in all things health. The long-term aim will presumably result in more bureaucracy (we are seeing this already), which will lead to higher costs to run the health insurances (already happening – need governmental support) and will very likely result in a decrease in services for the insured.

The anti-elitist/anti-science nature of the FPÖ's policy preferences also manifested in its harsh opposition to stricter anti-smoking laws and increased corona measures. In fact, this type of "science populism" is common in PRR parties, which often position themselves against theories

of climate change and are more prone to support conspiracy theories (Mede and Schäfer, 2020). In this case, the FPÖ propagated the interest of particularistic groups (smoking customers and small bar owners) while ignoring the advice of public health authorities. Although in opposition during the corona pandemic, the FPÖ went from approving the governments strict measures in the Spring of 2020, at times even saying that the measures were not strict enough, to finding the measures over-exaggerated and unnecessary by summer 2020. Upon the onset of the 2nd wave in the fall of 2020, the FPÖ settled on criticizing the governments lack of cohesion and their inability to present clear and legally sound measures.

Welfare chauvinism, particularly in social policies, along with conservative and liberal chauvinist structural health policies supported by the ÖVP and a general anti-science approach to health can be seen as the characteristics of FPÖ health and social policies. With the FPÖs current political standstill, however, further research would do well to look into the new ÖVP's health and social policies as they creep further to the right on the political spectrum.

The following chapter will look closely at two specific subnational cases in which the FPÖ spent a considerable amount of time in government. The cases of Carinthia and Burgenland will investigate the FPÖ's impact on health and social policies at the subnational level in order to leverage the national case.

Chapter 5 **: Austria's Subnational Cases**

"I would say health politics is always a very central question because health isn't everything, but without health everything is nothing" (Interviewee 1.5 Politician).

Carinthia

The political case of Austria's Southernmost province, Carinthia: population 561,077 (Eurostat, 2017), is one dominated by consistent charismatic faces, a populace whose National Socialistic past was not, like in the rest of Austria, repressed into unconsciousness (Ringel, 1988) and a historical border conflict that provoked political positioning surrounding the Slovene minority group. These distinctive legacies along with an atypical voter structure and a declining tolerance for the party book economy gave rise to the 14-year reign of the Populist Radical Right FPÖ as the strongest party in Carinthia.

This chapter will first lay out the political history of the province touching on the changes and shifts of political power since 1980. It will then analyze the uniqueness of the province by exploring the political persona of Jörg Haider (FPÖ) and his ability to dominate elections in a previously Social Democratic stronghold. The third section will depict the relationship the FPÖ in Carinthia had with health and health policies and the conclusion will disclose the provisional findings the case offers the study.

Political History

The province of Carinthia was "initially split under Napoleon's administrative reform in 1815: Upper Carinthia was controlled by Ljubljana and the southern Carinthian portion was controlled

by Graz as a so-called administrative body" (Interviewee 1.5 Politician). Up until the referendum of 1920, wherein the borders of Carinthia were defined and remained unchanged until this day, territorial claims against the province by the SHS state (Serbia, Croatia and Slovenia – former Yugoslavia) leading to defensive battles were typical.

It is with this historical background that the border conflict and the animosity towards the Slovenian minority groups living in Carinthia can be better understood. This important piece of history was never taken seriously by the Social Democrats and not politicized until the FPÖ came to power.

Up until 1989, the political landscape in Carinthia was dominated by the Social Democrats (SPÖ)[28] who claimed to stand for strengthening the Democracy, ensuring fair incomes, securing jobs and providing the Carinthian youth with work (Ratheiser, n.d.). Throughout the 70's and the 80's the Carinthian governors', Leopold Wagner (SPÖ), program for the province entitled "The Carinthian Way" reflected the Austrian Chancellor Bruno Kreisky (SPÖ) similar national program entitled "The Austrian Way". Both supported full-time employment despite the oil crisis as well as increased workers' rights and the general democratization of the state and the society (Ratheiser, n.d.) and were in turn supported by officials, professors and the well employed.

By 1984, Wagner's SPÖ found much support (31%) amongst those under the age of 35 and the charismatic leader had managed to install party representatives in all political districts thereby expanding his parties reach. By the late 1980's, however, membership in the SPÖ

[28] Aside from the governor position, there are always two provincial deputy governors and four councilors. Up until 1975 this SPÖ led Council was made up of a majority of SPÖ council members and a minority of ÖVP members. After this period, the FPÖ would have at least one seat in the Council at all times.

declined due to the premature resignation of Wagner as a result of a gunshot wound. Wagner was attacked and shot by a man furious at missing out on a promotion because he supported a different party; a phenomena known as "party book economy" (Ratheiser, n.d.). Replaced by Peter Ambrozy (SPÖ), a more pragmatic figure, the SPÖ lost its control over Carinthia to the FPÖ in 1989 and would not regain it until 2013.

The young charismatic Jörg Haider (FPÖ) managed to become Governor of Carinthia in 1989 despite the fact that the SPÖ held the majority in Council[29]. "This was a man that never said, 'we can't do this' or 'that doesn't work'. He always had a proposal for a solution, and he was someone that could speak to everything; he had an opinion about everything" (Interviewee 1.3 Politician). Charisma alone did not give him the edge over Ambrozy (SPÖ), he addressed critical issues such as the system of proportional representation which gave way to a "party book economy". He advocated for the fair treatment of people despite what party they belonged to or what occupation they held, he criticized the SPÖ under Wagner for their failed restoration of the Pulp Mill and most importantly, he sided against the Slovene minority group.

As Governor, Haider, backed by the ÖVP minority in Council, propagated a "policy of renewal" that was most reflected in the "objectification procedures" which saw to it that the hiring of state services were objective (Austrian Press Agency, 2004b). Haider's first stent as Governor was short lived as he lost the vote of confidence in 1991 after having mentioned the "ordinary" employment policy in the Third Reich (Interviewee 1.5 Politician). Haider was

[29] The SPÖ was still the strongest party after that election, but they were missing 800 votes thus unsuccessful in obtaining the 18th seat as there were only 17 left of the 36. The FPÖ gifted the ÖVP a seat and therefore Haider got the governorship with the ÖVP backing (19 to 17) (Interviewee 1.5 Politician).

succeeded by the head of the minority state parliamentary party, Christof Zernatto (ÖVP), a price the SPÖ gladly paid to overthrow the populist governor (Interviewee 1.5 Politician).

The ÖVP in Carinthia was divided into three big sub organizations form the very beginning: The Carinthian Farmers Association (KBB), the Austrian Workers and Employers Association (ÖAAB) and the Austrian Business Confederation (ÖWB). The latter association was the leading representative for the interests of businessmen and due to its financial strength had a significant influence on the ÖVP as a whole. In addition, the party was supported by the Hage-Bund, a national liberal trade federation that represented various professional trades. The ÖVP never really had a stronghold in Carinthia as their politics of solidarity, federalism and often austerity did not go over well with the Carinthia populous. In addition, this Christian Democratic party took a very lax stance towards the border situation with Slovenia and ultimately lost the governorship to Haider in 1999.

After the short period of ÖVP leadership, Haider led his party (FPÖ) to a victory in Carinthia and became Governor once again in 1999. During this time he suggested things like without immigrants the government's austerity budget would not be necessary (BBC News, 2000) and stressed the need to make Carinthia a more attractive workplace using his party's' position in the national government in 2000 to bring several projects – Magna, Mediaprint, etc. – to the southern province (Interviewee 1.3 Politician). Until his premature death in a car accident in 2008, the alluring man would retain the position of Governor, however the FPÖ would never have the majority within the state government[30].

[30] A majority in Parliament would consist of obtaining at least 19 of the 26 seats. The most the FPÖ/BZÖ ever attained was 17 in 2009.

After Haider's death, the BZÖ/FPK (Freedom Party Carinthia) under Gerhard Dörfler led the Carinthian government until 2013 when the finance scandal of the Hypo Bank (see Appendix C for details) was uncovered.

> *Between everyone that was involved in the Hypo scandal, 42 years of jail time was passed. The people, the voters of Carinthia, knew there was a big scandal and that the bank director was sentenced to 10 years in prison and many others stood accused before the court; the only people that were not directly involved or sentenced to jail time were from the SPÖ and the Green party* (Interviewee 1.2 Political Scientist).

And thus, the SPÖ was once again placed at the head of the Carinthian government and remains there to this day. In fact, since the 2018 election, the FPÖ party is no longer represented in the regional government[31].

The original FPÖ, founded in Carinthia in 1955, was based on the Association of Independents (VdU) and started as a "community of community" until it became a party of the masses in the 1990s (Ratheiser, n.d.). Initially, the FPÖ catered its program towards former National Socialists (NS) thereby supporting a reduction of the NS laws[32], fighting against the excesses of the state, opposing nationalism except in minority politics, campaigning for unrestricted competition and advocating for personal property. In addition, the FPÖ were able to cater to an enemy image created through the border situation in a very agrarian structure.

In the mid 1970s, under Mario Ferrari-Brunnenfeld (FPÖ), then Council representative in Carinthia, the FPÖ entered into a liberal phase campaigning with their "Manifesto on Social Order" (Ratheiser, n.d.). During this time, the FPÖ was against community consolidation, they

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[31] A major reason for this is because the election system in Carinthia was changed from a "proportional representation system", where every party – depending on its vote share - had a seat in government, to a Coalition government where it would be easier to tell which party was leading government and which was in opposition.

[32] NS laws are National-Socialist Verbotsgesetz or the Austrian Prohibition Act of 1947. This was a law against national socialist activities.

used Haider to fiercely target the youth and they initially prided themselves in having no national image. While in Council, Ferrari-Brunnenfeld installed a Tourism Department in Carinthia, which became the most successful in all of Austria. It was during the 80s that the "Wörthersee and the city of Velden were just as popular as Cannes and Monte Carlo" (Interviewee 1.3 Politician). Despite this liberal turn and the touristic successes, the FPÖ election results were poor and the 1979 National Council and Regional Council elections marked the end of the FPÖ's short lived liberal phase.

By 1986, Haider became chairman of the FPÖ wherein a significant push to the right ensued as the party began supporting the ethnic, anti-Slovene, policies brought forth by the Carinthian Homeland Service[33] (Kärntner Heimatdienstes – KHD). These policies included the rejection of bilingual traffic signs and the elimination of bilingual elementary schools.
With this movement to the right, Haider managed to win a seat in the National Council and became chairman of the health and environment committees. He was very active producing over 40 applications of which over 50% were successful. One of the most important applications was the 1993 referendum he brought forth entitled "Austria first". This was a reaction to the thousands of migrants that fled the warzone in former Yugoslavia and, among other things, wanted the Austrian Constitution to state that the country of Austria was not a migrant country.

> *Everything in this proposal from restrictive immigration to longer proceedings to become a citizen was subsequently implemented by the grand coalition SPÖ/ÖVP on a national level, but Haider was not given credit for it. Thematically, Haider quickly took control, but he was personally excluded from national politics* (Interviewee 1.2 Political Scientist).

[33] A German nationalist advocacy group in Carinthia that served as an illegal platform for the Nazi Party in Austria's 1st Republic where it supported anti-Slovene, anti-Slavic and anti-Communist policies. It was re-established in 1957 and significantly influenced political parties during public campaigns against Slovene minorities.

For the rest of the 90s Haider's flame at the national level diminished, mainly due to the dominant power of the SPÖ und ÖVP, while his support in the Carinthian state continued to increase. The FPÖ's share in the elections rose from 5% in 1983 to almost 27% in 1999 and by the 2004 elections in Carinthia, the last Haider would experience, his support reached 42%.

Jörg Haider and Carinthia

Some argue Haider rose to power because of the SPÖ's failed renovation of the Pulp Mill in Sankt Magdalen near Villach costing the province 1.3 billion Schilling (€95.5 million) and marking the decline of the all-powerful SPÖ in Carinthia (Coby and Papst, 2004). Others believe that his immense success in Carinthia was due to the fact that he was able to break up the proportional representation that gripped the country (Interviewee 1.3 Politician). A further line of thought argues that

> *Haider's success had a lot to do with the atypical voting structure in Carinthia wherein the high percentages of Protestants in the province along with the agricultural structures and the conflict with the Slovene minorities created a prime place for a leader that was good at speaking to lines of conflict and mobilizing them* (Interviewee 1.2 Political Scientist).

The truth can be found in the combination of all three. To begin with, the decline of the SPÖ began with the refinancing of the Pulp Mill, however many people in the province were already hungry for change before that financial disaster took place (see (Amt der Kärntner Landesregierung, 1999) for the Carinthian election results in 1999). The reasons for this desired political change can be seen in several different ways. For one, the SPÖ had been in power for such a long time that the party became rigid in its ways and appeared unable to adapt to the changing landscape of the world. They saw to it that professional promotions were given to those

who held the SPÖ party book (Grashäftl, 2017), they failed to see the struggles of the workers in the face of globalization (Nowotny, 2017) and their anti-fascist mentality prevented them from taking the border situation seriously (Heinisch and Marent, 2016). Haider used these points to propel his success helping him break up the proportional representation in the province.

Proportional representation, as described in the previous chapter, meant that there was a historic dominance of the SPÖ and ÖVP parties after the WWII. "Up until Haider came to power, everything in Austria was divided between red and black. There were red banks and black banks, red social insurance institutions, black social insurance institutions, red car clubs and black car clubs" (Interviewee 1.3 Politician). Everything was split between these two parties and the masses of officials that were tied to them left little room for the success of people that did not belong to one of those parties. The ÖVP, as previously mentioned, did not have a stronghold in Carinthia, but the SPÖ, always seen as the workers party, lost many of their voters to the FPÖ when it became apparent that the party book economy was only benefiting a few and the representation of the workers was becoming less important to the party line.

In addition, Carinthia's interesting voter make-up also played a significant role in the rise of the FPÖ. First of all, Carinthia had and still has the second highest percentage of protestants (10,3%) in the country next to the Burgenland (13,3%) whereas the provinces of Tirol and Vorarlberg only had 1,6% and 1,5% respectively. This is significant because in the provinces where Catholics dominated the populace the catholic ÖVP could count on a clear victory as was the case in Vorarlberg and Tirol where no other party ever had control of the government. Highly Protestant provinces were much more likely to vote for the FPÖ. Secondly, the Slovenian partisan raids in Carinthia during WWII and the disparate views over the minority protection

rights for the Slovenes after the war resulted in the problematic relationship between German and Slovene speaking Carinthians.

Finally, and perhaps most significantly, Carinthia was always seen as the outsider within Austria and thus "the Carinthian mentality was made up of caution and southern fatalism with a bit of a Slovenian imprint" (Interviewee 1.3 Politician). My interviews with officials, politicians and political scientists confirm that Haider, coming from Upper Austria, saw his goal in making the Carinthians proud of their province and this he successfully accomplished by increasing the provinces importance within Austria (Interviewee 1.3 Politician; Interviewee 1.5 Politician; Interviewee 1.2 Political Scientist). In the first black/blue national government with Schüssel and Riess-Passer (FPÖ) in 2000 Haider was able to "bring a lot of projects - Mahle, Mediaprint, Merks, Magna, etc. -, translating into jobs, back to Carinthia. This was significant as Vienna and Lower Austria were generally awarded these federal grants and projects" (Interviewee 1.3 Politician) and this led to an "immense increase in the Carinthians feelings of self-worth" (Interviewee 1.2 Political Scientist).

In addition to these points, Haider's triumph can also be attributed to his populist nature. The charisma that was Jörg Haider first showed when he was able to unite the scattered and extremely divided radical right in Austria under the FPÖ (Interviewee 1.5 Politician). At this point it became clear that the FPÖ was "not based so much on an ideology, but on just one leader – Haider – he held the party together" (Interviewee 1.2 Political Scientist). Considered one of the first populists, Haider always made the big promise that he would change the above mentioned party membership structure as he was, from the very start of his career in the 1970s, very critical of mainstream Austrian politics (Bailer and Neugebauer, n.d.). Due to his great communication skills and his general charismatic appeal many believed him. A former colleague claimed that

Haider "`made politics with money´ whether it was in the form of giving money to pensioners or handing out subsidies for heating bills. Haider was an excellent communicator and political tactician, and he knew what people wanted" (Interviewee 1.4 Politician).

> *Very typical of populist leaders and their parties is their ability to very quickly pick up issues that they believe should be different and issues that they want to change, with the main focus always resting on the destruction of big coalitions, structures and social partnerships* (Interviewee 1.2 Political Scientist).

In Carinthia, and for Haider, these structures and elites were the SPÖ.

Haider introduced many structural reforms during his time as he knew that only by changing the structures would he get his people, the FPÖ, into positions of power normally held by the SPÖ. "This is something that Haider was exceptionally good at: combining departments, changing them, or splitting them and thus being able to place new people in positions of power" (Interviewee 1.2 Political Scientist). He used simple slogans to exploit issues where he saw that the populace perceived injustice or the self-interest of big party politics (Bailer and Neugebauer, n.d.).

In addition, Haider started criticizing the elites, in Carinthia the SPÖ, arguing that:

> *Those people up there, they don't understand you (the normal worker). He even went so far as to call Chancellor Vranitsky (SPÖ) a `Nadelstreifsozialist´ (a pin stripe socialist) as he had previously been the director of a bank, thus `pin stripe´, and he vehemently supported the interests of the industry workers or the simple people, `socialist´. Haider was very talented in finding contrast and visually presenting it to people* (Interviewee 1.2 Political Scientist).

Through such communication, Haider, the populist, was able to get Communists, Socialists and Social Democrats onto his side.

Unlike the Social Democrats at the time, Haider was able to pick up on and use globalization to his advantage. He realized that there were groups that were not able to cope with

these extreme transitions, political science terms these people the "modernization losers" (Luther, 2003; Minkenberg, 2000), the introduction of computers, the opening of borders and the development of the European Union (Interviewee 1.2 Political Scientist). Throughout the 90s many people, particularly those that were less educated, felt increasingly threated by immigrants and generally feared that they were being left behind, those were exactly the type of people that he was able to get on his side (Quinones, 2017; Wischenbart, 1994). Haider led an aggressive populist style campaign throughout the 90s stressing issues such as political corruption, "over-foreignization and immigrant criminality and the values of the "little man" to win over these voters (Luther, 2003). This was the beginning of the shift for the working-class people from the SPÖ to the FPÖ.

The FPÖ and Health

In the case of health, there was a long-standing tradition that the Social Democrats dominated the health portfolio both nationally and sub nationally. The reason for this is that "the SPÖ had the most pronounced health political ideas and also the greatest acceptance amongst the population in this area" (Interviewee 1.5 Politician). Thus, it comes as no surprise that in Carinthia the reds (SPÖ) were always health advisors. "In general, health is not only a difficult job, it is a red stronghold" (Interviewee 1.3 Politician).

There were a few things the FPÖ did do however within the Carinthian health sector. First, they "dominated the supervisory board of the KABEG[34], Carinthia's hospital management

[34] In the Carinthian hospital management structure there are five houses located in: Klagenfurt, Villach, Hermagor, Laas und Wolfsberg, as well as six additional so-called fund hospitals (Fondskrankenanstalten). The fund hospitals are in part considered private as they are managed by a religious order and in part considered to be public hospitals as they can be accessed by anyone.

company, thereby limiting the competencies of the health advisor" (Interviewee 1.5 Politician). As head of the company, in accordance with the ÖVP, they wanted to reduce/eliminate the influence of the provincial government on the provincially owned hospital infrastructures and to "privatizes" these. Meaning, "the FPÖ and ÖVP worked together to turn these structures into self-made companies so that the political influence, that was primarily present through the SPÖ, could be reduced" (Interviewee 1.2 Political Scientist).

In addition, a major FPÖ goal was to minimize the structures within the hospitals, which was significant as "a not so small portion of the provincial budget" was dedicated to the hospital infrastructure in the province, meaning that this allowed them to place significant funds elsewhere if they kept administrations thin (Interviewee 1.4 Politician).

In fact, during Haider's second term 2000-2005, the "FPÖ wanted to close several regional hospitals and medical institutions to save money and produced several studies that would have led to clear cuts" (Interviewee 1.4 Politician). The SPÖ, in charge of the province's health department, argued that costs needed to be saved, no question, however these savings should be acquired through a better suited work distribution of the regional hospitals and a better endowment of the central hospitals i.e., the Klinkium Klagenfurt and Villach and not through the closure of any hospitals. The SPÖ argued that "closing these hospitals would have had major consequences as the regional hospital and medical institutions were important employers and built up important social structures" (Interviewee 1.4 Politician). The FPÖ on the other hand, wanted to employ people through the various projects Haider was bringing to the province:

> *He wrapped the city of Villach in gold when he brought them Infineon, the central warehouse for the supermarket chain Billa was moved to the city of St. Veit and he supported Wolfsberg, his argument was always why the metropolitan area (Klagenfurt)? It's so bourgeois we want to set the emphasis out there in the rural areas* (Interviewee 1.3 Politician).

The SPÖ easily deflected deals involving healthcare because it could be proven that such takeovers – privatization – would never be beneficial to the patients, rather it would only benefit the investor.

Aside from this disagreement over the hospitals and potential cuts, where the SPÖ position prevailed, the two parties initially agreed on all other healthcare related aspects which left the SPÖ to follow their agenda. The main goal of the Carinthian SPÖ with regards to healthcare, their flagship, was to provide "the best care for all no matter how much money is in your wallet." This is something the "people of the province gladly accepted, and we (SPÖ) were praised for never straying from this path" (Interviewee 1.4 Politician).

The general problem with the FPÖ and health was that "they did not have an identified health program" (Interviewee 1.5 Politician), this became increasingly clear after 2005 where the mostly harmonious relationship with the SPÖ run health department turned sour.

> *The FPÖ took what the SPÖ health advisor had and made its prioritizations as they saw fit. There were of course many things that the two parties still agreed upon, but in many areas the FPÖ wanted to forcefully pass things and disempower the political advisor* (Interviewee 1.4 Politician).

The FPÖ was "always vulnerable to proposals where services upheld their quality, but money could be saved" (Interviewee 1.4 Politician). German companies wanted to take over Carinthian medical structures time and time again and the FPÖ were easily persuaded by this as promises of increased savings were made. A prime example of such a case was

> *When the FPÖ appointed a certain Ms. Manegold from Germany as KABEG supervisor in 2010. She worked very closely with the FPÖ health speaker Kurt Scheuch which resulted in several lawsuits, Manegold's dismissal, and most importantly a very weak and inconsistent regional structural plan for health that lacked*

> *implementation due to the political opportunism practiced by the FPÖ* (Interviewee 1.5 Politician).

After a non-contested position was reached on the point of healthcare between all involved parties the SPÖ resumed complete control of the health advisory position without the interference of the FPÖ.

Conclusion

The FPÖ under Haider implemented many projects that, although financially questionable, instilled much pride into a province that was generally shunned by the rest of the country. Beginning with the Klinikum Klagenfurt, the most modern medical center of its time to the football stadium where sporting events, concerts and art installations are held, Haider's megalomaniac vision for the province took no end and was generally supported by the ÖVP; as was apparent in the finance scandal that erupted after Haider's premature death. With regards to health politics, not a classical strong suit for PRR parties, the FPÖ was able to relate more and better to the SPÖ and turned to them for parliamentary support.

Haider, although now suffering from a questionable reputation, undoubtedly created more jobs for the province and was successfully able to instill a sense of pride into the populace. However, "to give Haider any profile relating to health would be presumptuous. The health sector and the employee representation sector are two things that Haider didn't touch, he left these to the SPÖ" (Interviewee 1.3 Politician). This meant that decisions such as prevention strategies, ensuring public health services and implementing the federally regulated decisions generally fell into the hands of the SPÖ. The FPÖ for their part favored structural and administrative minimalism and privatization so that they could use the generous budget given to hospitals for other priorities. Surplus budget was used by the FPÖ to "take care of their own, while successfully shutting out the rest. They tried to do this using as little resources as possible

(in, for example, the healthcare sector) so as to be able to `buy´ political success" (Interviewee 1.4 Politician) in other areas.

The maintenance and survival of the healthcare sector in Carinthia can be attributed to the SPÖ as without their years of experience, diligence and conscientiousness many hospitals would have been closed, thereby significantly reducing the health budget. They also saved the province from sell outs to Germany, which would have left the healthcare budget severely strained, the unemployment rate higher than necessary and a very likely scenario of a two-tiered hospital system.

The provisional findings in the case of Carinthia come down to two main points: 1) avoid the health sector and leave it in the hands of the SPÖ. This generally worked out well unless the FPÖ thought they could squeeze money out of mergers, new appointments or proposed hospital closures. 2) focus instead on making the people happy. Bring back jobs to Carinthia, make the province important again in the eyes of Austrians, show the people that you are on their side not the Slovene or elite (SPÖ/Vienna) side. In summary, the Southeastern most province was dominated by a "Carinthian first" mentality during the FPÖ governorship, while the SPÖ involvement in the health politics saved the province from permanent health related catastrophes, such as the closing of hospitals, privatization and financial ruin.

Burgenland

Located in the countries Eastern most corner, Burgenland is home to only 293,433 people making it the region with the lowest population in Austria. In addition, the province of Burgenland is also the youngest addition to the country of Austria as it did not join the country

until 1921 (News, 2005). Previously, the province belonged to the Hungarian Soviet Republic, but was promised to Austria in the treaties of Saint Germain and Trianon after WWI. Switching between ÖVP and SPÖ led governments after its initial founding, the province settled on a steady stream of SPÖ governors starting in 1965 with the ÖVP as their coalition partner. In 2016, this dynamic changed, the SPÖ still had the majority in the province, but chose to form a coalition with the FPÖ. While this decision caused outrage amongst the federal SPÖ party, the cooperation worked mostly in favor of the SPÖ for several reasons: By giving the FPÖ a governmental role, 1) the FPÖ's criticism towards the government significantly decreased as they were no longer in opposition 2) the FPÖ's political support in the region decreased as they were given less significant roles that. These occurrences coupled with the general makeup of the region took the wind out of the FPÖ's short-lived sails making it an essentially uninfluential party in the governmental history of the province. This chapter will begin by looking at the countries historical and geographical makeup, then the political history of the country will be introduced followed by a section on the FPÖs impact on Burgenland. The conclusion will highlight why the FPÖ had no significant influence on the province and how this is different from the province of Carinthia.

Historical and Geographical Makeup

Three main historical developments are noteworthy to explain how Burgenland developed so differently from other Austrian provinces and perhaps more interestingly, how these developments then led to limited electoral ground for the FPÖ.

To begin with, and as previously mentioned, Burgenland was created out of a part of Hungary and this fact coupled with its geographical location (borders Hungary, Slovakia and

Slovenia) makes it a prime region for immigration. Croatians had been living in Burgenland since the 16th century (when the province was still a part of Hungary) and naturally Hungarians also resided in the province (Böse et al., 2001). "Burgenland never had any problems, contrary to Carinthia, with having Hungarian or Croatian town signs, it was just never a problem there" (Interviewee 1.5, Politician). In 1989, the province saw massive immigration with more than 45,000 former German Democratic Republic (GDR) citizens crossing the Hungarian border into the province (Fassmann & Münz, 1994) and again in 2015 the migrant crisis brought many immigrants over the Hungarian border into Burgenland. This implies that the province was used to immigrants as it was practically made up of immigrants from its formation making FPÖ anti-immigration slogans less appealing.

Secondly, when Burgenland was created in 1921 there was no natural center, meaning it did not have a single bigger city and was often referred to as the "Land of villages" (ORF, 2000). This also meant that the region had:

> *No area of high population density from which, social, economic and educational impulses could be set. So, it was very much an agriculturally structured area without identity. The population was very poor, the income, the possibilities the perspectives were significantly less than those present in other provinces and the problem was made worse by the lack of infrastructure. There were no connections from North to South. In the Hungarian monarchy the important infrastructural connections moved from East to West (Interviewee 1.8 Politician).*

What developed out of this infrastructure deficiency, even decades later, was a significant lack of education as well as a general absence of economic structures in the province. In 1960, the governor of Burgenland, Theodor Kery (SPÖ), referred to his province as the "Land of School Shame", meaning nothing more than that there were no educational institutions, and the Burgenland was an utterly underdeveloped region in every possible way (Lang, 1991). The rest

of Austria saw the province as "the poorhouse of Austria" (Wiener Zeitung, 2001). These sentiments began to change in the mid 1950's when the SPÖ led province invested a substantial portion of its budget into road construction (Atlas-Burgenland, n.d.) resulting in Northern Burgenland becoming better connected to Vienna and Southern Burgenland finding connection to Graz, the capital of Styria. With the beginning of motorization in the primarily agrarian province, income rose rapidly (Atlas-Burgenland, n.d.) and education was given more priority. These positive developments coincide directly with the beginning of the SPÖ's governmental majority as the party always had

> *1) a strong orientation towards blue collar workers, that involved support for transportation infrastructure, expanding commuting possibilities and increasing the provinces income. 2) The crucial point, however, is that they put immense effort in creating educational opportunities* (Interviewee 1.8 Politician).

The creation of educational opportunities leads into the final significant development that the province underwent. Prior to the 1960s, Burgenland had a particularly low number of high school graduates and an even lower number of university graduates. This trend changed significantly when the province received its own educational academy in 1962 as agreed to by the school act of that same year (Lang, 1991). The Burgenland made a substantial transformation with regards to its population moving "from a previously agriculturally based population with a high number of blue-collar workers to now becoming a region, along with Carinthia, that has the highest number of matriculations in all of Austria" (Interviewee 1.8 Politician).

While substantial improvements have been made in the province, there is still much catching up that needs to be done.

> *If we look back at these last 10 years, we are still trying to align with the prosperity, education, healthcare and income level of the other Länder, but has had a distinctly steeper development curve than other regions, and this is also a part of the identity of Burgenland. Things are*

> *moving forward, there is positive development and there are also positive future perspectives (Interviewee 1.8 Politician).*

Interestingly, the three developments that embossed Burgenland were further supported by the European Union (EU) when Austria joined in 1995. Burgenland "was given an additional positive impulse not only through freedoms granted by the EU in the economic sense (free movement of persons and goods), but it was also given more financial aid as it belonged to those areas where the per person economic power was under 75%. This meant it was eligible for and received 'Objective 1' funding (European Commission, n.d.), the highest funding possibility from the EU regional development pot" (Interviewee 1.8 Politician). Burgenland profited significantly from the European Union contributions (ORF, 2014) causing them to have a very favorable attitude towards the EU. In fact, the FPÖ called for a EU exit referendum in 2015 wherein the countries citizens were put to vote – Burgenland was the country with the least amount of votes supporting the referendum (Bundesministerium fürs Inneres, 2015) making it clear that the FPÖ could not count on support from the province.

Political History

Theodor Kery (SPÖ) was the figure that broke through the ÖVP majority in Burgenland controlling the fate of the province for 21 years and granting the SPÖ the majority in parliament four times. The party did not lose the majority until 1987 after which Kery himself stepped down. Initially Kery inherited a very underdeveloped Burgenland, however, he was able to promote growth. The agricultural sector shrank in Kery's term by two-thirds, the structural change favored the SPÖ: They advertised in the 1982 election campaign "Theodor Kery: The Straight Path" – and all understood that it was a way of modernity (Seidl, 2010). People

remember him as being confident and convincing (Schwarz, 1998), but he was criticized for not supervising the associations (Genossenschaften). After 1987, the then head of the FPÖ, Jörg Haider, created a pact with the ÖVP general secretary, Michael Graff, that Burgenland would no longer have an SPÖ governor, rather the ÖVP candidate Franz Sauerzopf. This agreement failed when an FPÖ official, Gregor Munzenrieder, voted against the plan resulting in a tie between SPÖ candidate Hans Sipötz and Sauerzopf (Standard, 2002). The result was that the SPÖ, being the strongest party, had the right to propose the governor.

Hans Sipötz was quickly replaced by SPÖ governor Karl Stix, but both were rather unremarkable governors. The one thing worth mentioning is that in 1996, during Stix' second term, the SPÖ/ÖVP provincial parliament was infiltrated by the FPÖ for the first time taking away one of the SPÖ's four member seats.

By 2000, the red province was turned over to Hans Niessl (SPÖ). His parliament went back to being dominated by the SPÖ/ÖVP, which lasted until 2015. In the 2015 provincial elections the dominant parties SPÖ and ÖVP lost 6,34 % and 5,54 % of the votes respectively while the FPÖ gained over 6%. This put the FPÖ in third place, but with the change of the provincial constitutional law in 2014, the proportional representation was eliminated and thus the free formation of government ensued. The SPÖ, therefore decided to form a coalition with the FPÖ instead of the ÖVP and thus the PRR party was allotted two seats in the Nissl IV government. Johann Tschürtz (FPÖ) became deputy governor under Nissl and responsible for security while Alexander Petschnig (FPÖ) was given the economic and tourism portfolios. This constellation was kept when Hans Peter Doskozil (SPÖ) became governor in 2019.

Choosing to govern with the FPÖ was an intelligent strategy as the SPÖ ended up with five seats in Parliament instead of only having four if they would have chosen to form their

coalition with the ÖVP again. The drawback was that Nissl and later Doskozil were heavily criticized for going against the Vranitsky doctrine as the SPÖ was always strictly against coalitions with the FPÖ. This "forbidden" coalition led to two consequences on the national level: First, in 2015 shortly after the FPÖ was asked to join the government of Burgenland, the then chancellor of Austria Werner Faymann was called upon to resign by his own party members as they claimed he no longer had his party under control. Secondly, several prominent SPÖ officials threatened to leave the party due to the newfound red/blue coalition in Burgenland (Hasewend, 2015).

Niessl's accomplishments for the province are many beginning with the creation of 30% net additional jobs, followed by the fact that the Burgenland generates 150% of the electricity demand through renewable energy and with regards to tourism, boast more than three million overnight stays. In addition, Burgenland is the number one start-up company in Austria with 80% more startups since 2001 (Stefanitsch & Millendorfer, 2019). With regards to health and social services the former governor alludes to the creation of 30 nursing homes as well as providing location guarantees for all the hospitals in the province. In a 2019 interview he stated: "Good care, that's the short way to a long life" (Stefanitsch & Millendorfer, 2019). Under his guidance, Nissl claims that the province had "the highest economic growth of Austria within the last 18 years, the highest graduation rate and the best skilled workers. In addition, the purchasing power also moved from Vienna to the Burgenland" (Stefanitsch & Millendorfer, 2019).

Starting in 2016, the SPÖ in Burgenland entered a coalition with the FPÖ – a taboo break. Former governor Nissl states, "the three and a half years with the FPÖ were a successful time for Burgenland and that times with the ÖVP were oft difficult is normal over a period of 15 years" (Stefanitsch & Millendorfer, 2019).

Burgenland and the FPÖ

The 1956 Parliamentary elections were the first in which the FPÖ was present. Contrary to the country's more Southern province, Carinthia, the FPÖ did not have nearly as much electoral success. By 1987 the party reached over 5% in the parliamentary elections (7,31%) and began slowly growing (see Table 1 below) making itself known as an opposition party that was not afraid to criticize the SPÖ/ÖVP provincial government. Although the FPÖ had a short stint in the 1996 SPÖ/ÖVP coalitional government, the FPÖ was clearly the junior party and was only given one portfolio encompassing both the cable care system and food control, while the other two parties received three portfolios a piece including the governorship and vice-governorship. Beginning in 2000, the FPÖ found themselves constantly in, a position that suited them (Interviewee 1.8 Politician) as they consistently criticized and spotlighted things that were not going well, i.e., patronage and not sufficient civic involvement in political decision making.

> *The FPÖ in Burgenland always had the lowest provincial parliament election results, I think, in relation to other Länder. Why? I think one point, the Burgenland was, longer than in other regions, made up of predominately blue-collar workers. Here in Burgenland, you can probably count on two hands the amount of industrial business there are and 97% of all business are small or middle. So, here the SPÖ found a population structure that more than not meshed well with their program as elsewhere. Another point, the small structure of the province. It is very assessable, meaning that politicians here can be everywhere and have this closeness with the people that it is often hard to establish elsewhere. It doesn't matter if they are promoting a new fire truck, if it's a sports match, something cultural, 300.000 inhabitants have the possibility to be in contact with politicians in a very uncomplicated way* (Interviewee 1.8 Politician).

The SPÖ was able to keep a closeness with the citizens over the years and being a more established and bigger party, they did not leave any room for the FPÖ. By the 2015 elections, the migration crisis was in full swing and the FPÖ, both nationally and subnationally, used this to its

advantage. Slogans such as "The flood of asylum seekers is rising unchecked!" or "Did you know that you will become a stranger in your own country?" (Hengst, 2015) filled campaign posters and speeches creating uncertainty in the country and in the province. Not surprisingly, the FPÖ profited electorally from this occurrence gaining 6%, putting them at 15,04%. The votes gained by the FPÖ came from dissatisfied SPÖ/ÖVP voters as both parties lost 6,34% and 5,54% respectively.

Although the FPÖ was still in 3rd place by far with regard to the overall election results, former governor Hans Niessl, now potentially entering his 4th term, noticed the growing strength of the FPÖ (See Table 1 below) and decided to join forces with them.

> *I wouldn't excessively romanticize this. This was a quick decision that could have probably only been reached as such. Because if Nissel didn't quickly form an agreement with the FPÖ, then the ÖVP would have formed a coalition with the FPÖ and then the governor would have been gone despite having the strongest party and a clear electoral lead. I saw this less ideologically motivated and more pragmatic. But, of course, there is – Pause – In a party with these anti-fascist traditions and with a clear delimitation towards the FPÖ such as the Social Democrats have – Pause – This became an issue beyond the party itself* (Interviewee 1.5 Politician).

Niessl found forming a coalition with the FPÖ as being "the lesser of two evils as he knew that the FPÖs role as being the protest party would disappear when in government seeing as one simply does not criticize their own government" (Interviewee 1.8 Politician). The FPÖ was given two roles in Nissels 4th government: Party head, Johann Tschürtz (FPÖ), became deputy governor and was in charge of the security portfolio and Alexander Petschnig (FPÖ) was given the portfolio Tourism and economy, all of the other portfolios including health stayed in the hands of the SPÖ.

While it seemed like the FPÖ played a rather insignificant role in the Niessl government, their hardline on immigration began influencing the SPÖ governor. In 2016, Niessl told the media that "in areas where unemployment is particularly high, the free movement of people must be restricted, for example in construction and related trades," which gained him prompt support from his coalition partner Petschnig (FPÖ), who added, "In view of the drama of the situation (referencing the migration waves), a sectoral closure of the labor market is the order of the day" (Orovits, 2016). Interestingly, both SPÖ and FPÖ were only speaking about the construction industry and not the tourism industry seeing as foreigners made up 54% of the tourist industry in Burgenland whereas construction "only" counted for 35% (Orovits, 2016). Looking at the other industries, agriculture boasts 74% foreign workers in the province and healthcare, specifically carers, are made up of mostly "independent", self-employed, female, foreign nurses who are placed through agencies (Sitar, 2019). Currently, there are about 2,300 people living in 45 nursing homes in the province and it is estimated that of the approximately 1200 employees in these homes, around 300 are from abroad, including an estimated 200 from Hungary (Fohringer, 2020).

As to actual accomplishments, the FPÖ Burgenland party head, Géza Molnár, stated in an interview: "we put an end to the debt policy, there are more jobs, more employers and the tourism numbers are better than ever, and we made Burgenland safer" (Tscheinig, 2019). In addition, the FPÖ official claims that the coalition does not argue as was previously common under SPÖ/ÖVP and instead works together in a very solution oriented, trusted partnership.

The FPÖ managed to stay in government with two portfolios (safety and the economy as well as tourism) from 2015 until 2020 after which the new governor Hans-Peter Doskozil (SPÖ)

won the absolute majority and did not need a coalition partner. This election was very unique in that:

> *Contrary to the national elections (took place in September 2019) where disappointed FPÖ voters moved to the ÖVP, here in the Burgenland the disappointed FPÖ voters moved to the SPÖ. And I will say it like this, distinct from Hans Niessl who actually followed the same concept, but stood still. Niessl tried to win an election solely on this terrain and didn't realize that one has to move a bit into the terrain of the FPÖ or ÖVP. Instead, Doskozil understood how to prioritize the areas that were also important to the FPÖ voters (those that felt left behind) such as making childcare free. He introduced a minimum income. Although this is a small number with regards to the number of employed, but the signal he sent out was very big* (Interviewee 1.8 Politician).

In the 2020 Burgenland elections (see Table 9), former FPÖ voters (37%) as well as former ÖVP voters (19%) and even non-voters moved to the SPÖ (SORA, 2020). This was surprising not only because of the distribution of votes, but also because the SPÖ, just a few months prior during the national elections, had to accept historic losses (Jaeger, 2020). So, how and why did this happen?

One explanation is that Doskozil had always been known to stand for and pursue rather strict immigration policies, which is very distant from the federal SPÖ party focus. A further explanation, more closely related to the SPÖs traditional support for the welfare state, was that his campaign leading up to the provincial elections actively promoted a strong socio-political orientation. He promised that state employees would receive a minimum wage of 1,700 euros net and that mobile care would be further expanded and improved.

> *Doskozil understood how to prioritize the areas that were also important to the FPÖ voters (those that felt left behind) such as making childcare free. He introduced a minimum income. Although this is a small number with regards to the number of employed, but the signal he sent out was very big. Finally, there is someone that cares and sees that the gap between rich and poor is drastically increasing* (Interviewee 1.8 Politician).

This combination of a more generous welfare state and a hardline on immigration was very likely what prompted FPÖ voters to move to the complete opposite side of the party spectrum and also made it more palatable for ÖVP voters to make the jump as well, albeit one that was not as far.

Table 5.1 FPÖ Election Results in Burgenland.

Year	Votes in %	% Change
1991	9.74%	+2.43
1996	14.55%	+4.81
2000	12.63%	- 1.92
2005	5.75%	- 6.88%
2010	8.98%	+ 3.23%
2015	15.04%	+ 6.06%
2020	9.79%	- 5.25%

Source: (SORA, 2020).

Conclusion

As can be deduced from this section, the influence of the FPÖ on health and health policy in Burgenland was slim to none. This, in itself is an important finding as it confirms that the FPÖ's preference for the issue of health is subject to the power of the SPÖ since that is their preferred portfolio. This is also reflected in the national case (Chapter 4) where the FPÖ is only given the health ministry when the SPÖ is not included in the governmental coalition. Without a health portfolio it is difficult to impact health or health policy.

The case of Burgenland is nonetheless and interesting one in that it clearly demonstrates how the FPÖ can be shut down. By joining forces with their most critic filled opposition party, the SPÖ managed to silence the FPÖ thereby decreasing their power and influence. In addition to this strategy, the SPÖ in Burgenland also adopted the FPÖ's anti-immigrant stance coupled with

their own position on welfare expansion to win the absolute majority in the province. This shows that a PRR party can, in fact, be defeated.

Carinthia and Burgenland Conclusion

There are three significant differences between the two provinces that are very likely also the reasons as to why the FPÖ was so much more present and successful in Carinthia as opposed to Burgenland. To begin with, there is the element of demography coupled with geography. Burgenland was and still is the least populated province in Austria wherein the biggest city, Eisenstadt, only has an inhabitance of about 15,000 people. This demographic fact resulted in the provinces close knit community wherein the "municipalities that makeup the province felt a stronger responsibility towards one another and made a great effort to stick together" (Interviewee 1.8 Politician). Carinthia, by contrast, has two city centers, Klagenfurt (almost 100,000 residents) and Villach (61,000 residents), making strong connections more difficult to form. This disunification played into the FPÖ theme of creating in and out-groups much more easily and was thus also more acceptable to the Carinthians than to Burgenlanders.

Secondly, both provinces had very different histories with regards to immigration. Burgenland was essentially made up of ethnic groups since its existence as an Austrian province with everything from Croatians to Hungarians to Roma and Sinti groups making up the population. In addition, religions were also very mixed, with everything from Jews to Protestants and Catholics living side by side. Carinthia on the other hand spent most of its post war history fighting against the Slovene minority group in the province. There were always "little conflicts and political positions that one could take to support the Germanness of the province and the

Austrian homeland" (Interviewee 1.5 Politician). This made Carinthia ripe for anti-immigrant sentiment more so than in any other Austrian province.

Finally, because Burgenland was such a poor province, recall the previous description "poorhouse of Austria", there were no elites that the FPÖ could rally citizens against. So, while the FPÖ pitted Carinthians against the SPÖ as being elite and detached from the everyday worries of the blue-collar laborer, the FPÖ in Burgenland was unable to assume a similar role because the SPÖ was, in fact, very supportive of the blue-collar workers in the province, seeing as that was the predominant voter group.

In addition to these differences in geographical make-up, history and population, Austrian provinces have a relatively small role in shaping health policies. To being with, the way the competencies are divided in the realm of health (see Figure xx in Chapter 4) leaves the provinces with no legislative power. In fact, the provinces are tasked with ensuring implementation for legislation passed by the federal government, ensuring hospital care and ensuring health promotion and prevention strategies. In combination with the federal government, they are also tasked with the planning of in-patient care in hospitals and the implementation and administration of public health services. This distribution of powers implies that holding the health portfolio within a given province is rather uneventful when thinking about health policy impact. The bottom line is that provinces do not make health policy, the health ministry does. This dynamic can be clearly seen with regards to the COVID-19 pandemic response highlighted in Chapter 8.

In addition, in no province has the FPÖ ever held the health portfolio. Thus, even if the subnational level was responsible for health policy making, there were never any FPÖ party

members in charge of that portfolio. Thus, it is safe to say that the FPÖ's influence on health as demonstrated by the subnational cases was rather minimal.

In summary, PRR parties are only able to develop into strong parties under certain conditions and they are only able to directly impact health if given that portfolio and power (which is nearly impossible at the subnational level seeing as health policies are made at the federal level). In both of these provinces the FPÖ's impact on health was limited not only by design, but also because they were not given the health portfolio seeing as they were in a coalition with the SPÖ (Burgenland), or they simply chose to focus their efforts on something else (Carinthia) because health was out of their league and better left to the SPÖ. In both cases, as well as generally speaking, health policy is not made on the subnational level.

Chapter 6 **: The National Case of Italy**

The Italian System

In Austria, a Bismarckian healthcare system was observed, while Italy follows the Beveridge model. This implies that in Italy healthcare is financed through taxation as opposed to social insurance contributions. A Beveridge system brings with it a meticulous budget that one will never find in a country like Austria, however, I chose not to focus on the money flows within the public sector of Italian national and subnational governments and instead chose to focus on the policies passed on both levels of government. I do this in order to find some common ground between the very different cases.

There are three vital things to remember when thinking about Italy as a case. The first is that the Italian NHS is a "three layer" universal healthcare system free at the point of care. The second point is that healthcare is decentralized in Italy implying that there are essentially 21 different healthcare systems in the country. The final point is that the Northern regions are substantially wealthier and have better medical facilities than those of the South. These three factors become even more relevant when thinking about the COVID-19 pandemic discussed in chapter 8.

The chapter is structured similarly to chapter 4, beginning with an overview of the Italian system, including the political and healthcare systems. A short section on healthcare financing and exceptions to the general healthcare rules follow before turning to the national case of Italy.

Within the case section the history of the Lega Nord is explored followed by the health policies the Lega advocated for and passed over time. The chapter ends with a short conclusion.

The Political System

The Italian state is a parliamentary, democratic republic with a multi-party political system (Ferré et al., 2014). According to general classifications, Italy is considered a parliamentary regime meaning that parliament and the prime minister have more authority than the president. Some scholars would go as far to say that Italy, post WWII, is neither a presidential nor a parliamentary regime, but rather a particracy (Calise, 1994), which can be defined as a form of government for which political parties are the primary basis of rule. This form of "party government" occurs when one or more parties hold a monopoly of access to government personnel, government resources, and government policies (Lowi, 1992).

The role of Italian President was initially designed to be more of ceremonial one known as a rather "ambiguous" office (Paladin, 1986). Since the turbulent governments starting in 1994, this role has been redefined to take on more of a political presence (Pasquino, 2012). Some authors go so far as to say that the President of the Italian Republic has the most powers among all the parliamentary governments of Europe (Tebaldi, 2014), despite not having any executive powers (Amoretti and Giannone, 2014). Generally speaking, the most important powers that the Italian President holds are:

- the formation of government and the appointment of its ministers, including the Prime Minister
- the dissolution of Parliament
- the power to call new elections

- the ability to authorize the introduction of governmental bills
- the declaration of the laws

The President of Italy, does not however, have the ability to influence the timing of and the dynamics surrounding a governmental crisis.

Before 1992 no Italian President was ever called upon to decide whether Parliament should be dissolved, however as will be explained, after 1994 this became more frequent beginning with Berlusconi and then Prodi in 1998 (Pasquino, 2012). When political parties in Italy are weak the ability of the President to act on his institutional and constitutional powers expands. Essentially this is what happened during the 1992-1993 period in Italy when the entire party system collapsed and a new party system emerged in 1994 (Newell, 2000).

The first case of the Italian Constitutional Court was heard in 1956 (Volcansek 1999) and it was assessed as having a very progressive role within Italian politics (Sassoon 1986). Important variables to consider when assessing any court system, but particularly the Italian one as the criteria was written for Italy according to (Volcansek 1999) are:

Independence – judges must be able to decide impartially meaning they have "some degrees of freedom from one or more competing branches of government or from centers of private powers such as corporations or religious organizations" (Schmidhauser 1992). The selection of judges to the Constitutional Court is solely a political one, however judges can only be appointed for a single nonrenewable term (Volcansek 1999) thereby minimizing the political clout.

1. Maintaining constitutional equilibrium – how does the court treat executive decree laws versus the legislative branch?
2. Accountability – the assessment of the judge's standings

3. Access – who can bring a case. This Court decides on the constitutionality of laws and actions having the force of law and it resolves conflicts within the government.

Unlike in the Austrian case, the Italian justices are never appointed for life (Cole 1959). The requirement here is that five of the judges must be selected by a three-fifths majority of the two houses of parliament. In both countries, the courts have the power review the constitutionality of federal and state, or provincial and regional, legislation intervening in disputes involving "conflicts of competence" between the central governments and the states, provinces, or regions, as well as between these latter political units. They also can decide jurisdictional disputes between organs of government, however only in Austria are they able to decide jurisdictional disputes between the courts, or courts and administrative authorities (Cole 1959). As far as impeachment is concerned both countries can try accusations against certain officials at the national level, but only in Austria can the Courts try officials at the federal and provincial levels. In both Austria and Italy, individual access to the Court is limited, whereby it is more limited in Italy as there is only one procedure of judicial review – in Austria there are two. Constitutional complaint, as it exists in many other countries is unknown in Italy and only available in a modified form in Austria. Thus, it seems that the Italian courts have implemented the most restrictive view on equal protections (Cole 1959).

In Italy, the appointing authority is divided to incorporate three separate branches of government: 15 judges in total are appointed for one non-renewable nine-year term. Five judges are named by each, the President of the Republic, parliament in a joint sitting, and judges on the ordinary and administrative courts (Volcansek 2001). Before the reconfiguration of political

parties in 1994, there was an allocation of appointment among political parties meaning that two judges were appointed by Christian Democrats, one by the Socialist party, one by the Communist Party and one was a rotating appointment between the three main parties (Volcansek 2001). Judicial independence cannot be counted on as appointments are made based on party loyalty, meaning that the appointments are very much influenced by which parties are currently in power (Volcansek 1999). To offset this fact, judges can only be appointed for a single nonrenewable term (Volcansek 1999) thereby minimizing the political clout.

The Italian Constitutional Court is an important political actor (Volcansek 1999) and has been established as a significant example of a veto player, in other words as an influential actor (or agent) in the policy-making process (Baschiera 2006). The role of the Court is one of a watchdog, keeping an eye on what the executive and parliament do and making sure these actions hold up in the Italian Constitution. Because this Court has the power to review legislation in order to monitor the rules, the position of the Court is elevated to one of a major decision maker or breaker (Volcansek 2001).

The failure to decide jurisdictional disputes between courts, the inability to try officials at a national level and the fact that judges are very influenced by political parties despite their single unrenewable term give the Italian Constitutional Court slightly less independent power than the Austrian one. Three important parts of the Italian constitution pertaining to health are Articles 2 and 21 that guarantee the human rights and freedom of expression, respectively, as well as Article 32. This latter article states that the Republic protects health as a fundamental right.

Parliament

The Italian parliament is a bicameral legislature with a total of 945 elected members. The Chamber of Deputies is the larger of the two chambers and has 630 members (each elected on a national basis) while the Senate of the Republic only has 315 members (each elected on a regional basis with six senators for life). Although these two houses are independent, they each possess the same powers, no distinction is made between senators and deputies other than their age at the time of election and both are elected every five years (Senato della Republica n.d.).

The main function of the Italian Parliament is to enact laws. Similar to the United States, in order for a bill to become a law it must be approved by both chambers containing the identical text. A further important function of Parliament is also to review the actions of the Government and when necessary, provide political direction. In fact, they are the ones that bring a new Government to life through the "vote of confidence" thereby also establishing guidelines that executive has to follow (Senato della Republica n.d.).

An interesting fact about the Italian Parliament is that it has one of the highest rates of legislative production in the world (Giuliani 2008). See Appendix B for an analysis of the various Parliaments starting in 1996.

Clientelism

The notion of clientelism played, and still plays an exceptional role in Italian politics. While clientelism was present well before the 90's[35], I will use a concrete example from the 90s to explain its expansive influence:

[35] Before the 90s, Italian parties avoided placing too much emphasis on political leaders, such as the Prime Minister, this radically changed with the introduction of Silvio Berlusconi, Umberto Bossi and Romano Prodi (Pasquino, 2001). With these strong figures, Italians began linking their support for these men to the political parties they belonged to, and not the other way around.

> *Corruption in parliament was one of the main reasons people started looking for new parties to vote for. With the end of the 1st Republic (1946 – 1999)*[36] *and the beginning of the 2nd Republic in 1999, everything was different politically. And it was during this time that Berlusconi was strongly connected with the Socialist Party, particularly Bettino Craxi. There were investigations later showing that Craxi was a relevant player in allowing Berlusconi to have all the conditions to develop his media empire. Because Berlusconi was the first to develop a private media empire. What happened is that Berlusconi decided to enter into politics because of the risks he was confronted with seeing as he no longer had people in politics to support his interests. He was no longer covered in politics because the old politicians were no longer in power. So, the first modern populist was born with Berlusconi in 1994. Not an extreme right as defined now, but right at the time* (Interviewee 2.16 Political Geographer).

Put differently, "The institutional penetration of the Christian Democrats (DC) into Italian society was strengthened insofar as individuals found political advantage in working through DC links … Patterns of clientelism and favoritism spilled over into outright corruption, however, popular revulsion against which eventually triggered the collapse of the old party system" (Gunther and Montero, 2001, p.139) and the birth of the Second Italian Republic. This is to say that the amount of corruption scandals had increased so sharply leading up to the Second Republic, that Italians declined to identify themselves with any party (Gunther and Montero, 2001; Menapace, 1974). This led to the decreased support for the traditional parties, the Christian Democrats, known as the white party, on the one hand and the Italian Socialist Party, known as the red party, on the other. With less support for the two largest parties in Italy, the Catholics and the Communists, spaces on the political spectrum for new parties were beginning to open. It is because of this opening that parties such as Forza Italia (FI, center right), the National Alliance

[36] Dominated primarily by the Christian Democrats who retained their influence by keeping the Italian Communist Party (PCI) out of power.

(AN, far right) and the Lega Nord (LN, between FI and AN) could begin to find support on the national level.

National Healthcare System

The Italian healthcare system has a mixed-public private system of provision, wherein healthcare is provided by a regionalized tax-based the Italian National Health Service or (SNN – Servizio Sanitario Nazionale), following the Beveridge model of healthcare. This National Health Service, "very similar to the British health service, was created with the healthcare reform in the late 70's. Originally, it had a very limited, very small role for private providers" (Interviewee 2.6 Medical and Public Health Expert). During the last few decades Italy, like many other countries, has seen a transfer of health competencies from the national to the regional level (Greer, 2016). This step was solidified in 2001, when the final constitutional amendment relating to health was implemented in Italy. Herewith, the regions gained full autonomy in organizing and managing their healthcare services while the Senate was given the task of formulating general principles and the national government provided the finances (Toth, 2014). In essence:

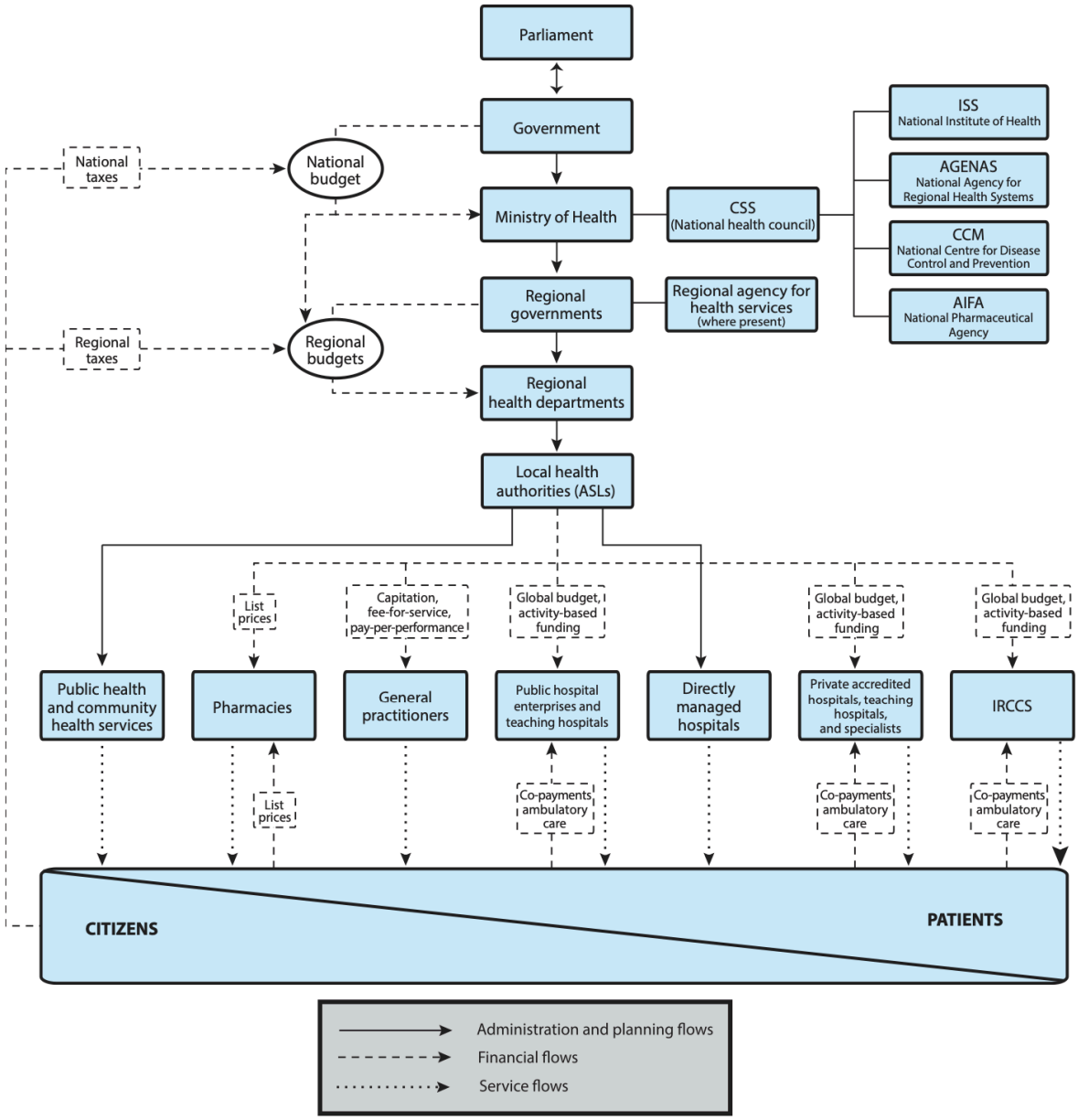
> *The national government decides for general issues, like a frame, but then article 117 of the constitution asks regions to freely organize themselves inside the given frame. And the frame is pretty wide. Law 552 of 1992 outlines the general, universalistic criteria (LEA or essential levels of care), but then the region decides. The government gives the budget, and the government checks every year whether the minimal standards (LEA's) are respected, but it is up to the region to decide how to spend the money. The regional government has more power on the realization of the services, of course every year each region says, 'we need more money'* (Interviewee 2.1 Health Official).

Thus, since the early 90s every regional government has created its own healthcare system, and each region, not the national government, is solely responsible for creating, organizing and financing its Regional Healthcare System (RHS) in relation to specific territorial peculiarities,

health needs and resources (Perna, 2018; Tediosi et al., 2009). Therefore, one can consider the country being made up of 21 different regional health services (Mapelli, 2012).

As can be seen in Figure 10 below, the Ministry of Health, despite the devolution, still plays a rather central role within the SSN. The biggest task given to the Ministry is determining the overall budget for the SSN (Ferrario and Zanardi, 2011). Funds are allocated according to a complex formula that is based on population size, average age, mortality rates and other regional characteristics, such as spending levels (Giannoni and Hitiris, 2002). The money from the Ministry of Health is given to the Regional Health Authorities (RHA) and then further distributed to the Local Health Agencies (ASLs). An additional task assigned to the Ministry is to define what services are included within the guaranteed basket of services provided by the 'essential levels of assistance' (Livelli essenziali di assistenza – LEA). The national government has the exclusive authority of determining what is in the guaranteed basket of care (WHO, 2016) and each region must provide, at least that. They can provide more services, but not fewer.

Figure 10 Overview of the Italian Healthcare system

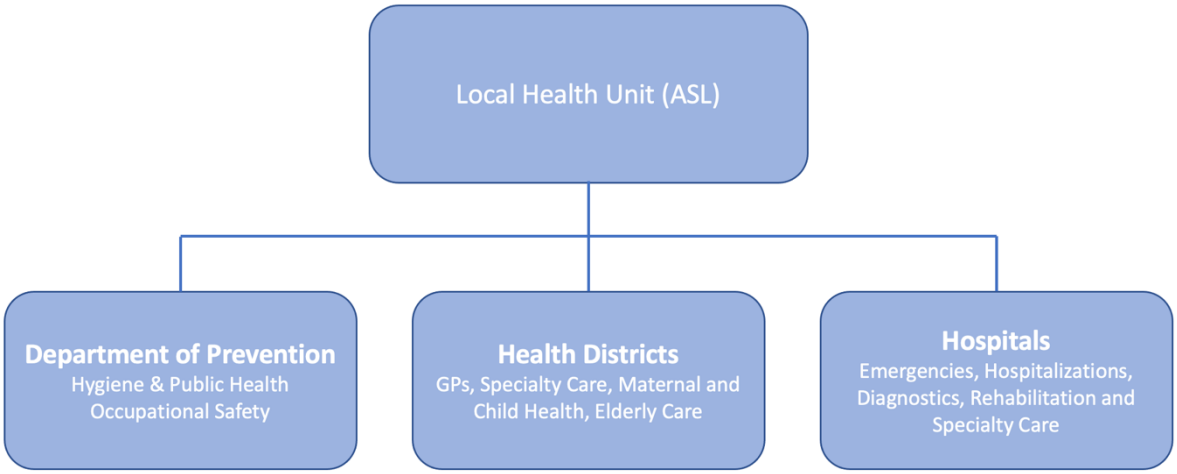


Source: (Ferré et al., 2014).

In summary, when thinking about the healthcare system in Italy it is important to realize the that there are three key actors: 1) the central government (Ministry of Health, Ministry of Finance), 2) the regional government and 3) 200 local health units (ASLs) whom are responsible

for the health of the population in a given area and 100 independent hospitals (Anessi-Pessina et al., 2004). Figure 11 gives a quick overview of the ASL structure:

Figure 11 Local Health Units (ASL)



Source adapted from (Mapelli, 2007).

This dissertation and the following chapters will not focus on the devolution of the Italian healthcare system as the time period of interest is post 2000 for my national and subnational cases. For an overview of the devolution see (Toth, 2014) and for healthcare reforms pre 2000 see (Giannoni and Hitiris, 2002). The rest of this section will instead, touch on a few important points that one needs to know about the Italian system and how healthcare is implemented.

Financing Healthcare

The country's main source of health financing is national and regional taxes, supplemented by co-payments for medicine and outpatient care (WHO, 2016). 95% of the NHS is funded through direct and indirect taxation, the rest comes from the regional health institutions and from

"tickets"[37] paid directly by patients (Cicchetti and Gasbarrini, 2016). As explained by an Italian health official:

> *The national health budget is discussed year by year, to decide whether it should be increased and by how much. Under Matteo Renzi (2014-2016), for example, there was a time when the health budget was not increased because it was decided that it was not possible to give more money to healthcare because of a deficit with Europe. Then there was an agreement to increase the budget a little bit, and that is how we arrived at the current number. Now, the new government will have to either take money from a different area or increase taxes, if they want to increase the health budget. Healthcare needs an increase in budget: more elderly people, longer life expectancy, new medicines, new technologies, it's a growing trend. To keep it the same, it's the same as reducing it* (Interviewee 2.1 Official for Health, Welfare and Sport).

In essence, what occurs, is that the citizens of the regions pay taxes, these taxes, for all but five regions[38], go to the national government. The government then, depending on the country's economic situation, the party in charge and how well the region met its health goals, decides how much money to allocate to a specific region for health.

> *The financing of the health system is, even though in many documents or in papers is written something else, is absolutely centralized, so that all the money necessary to finance the national services are collected in Rome at the central level. There is an overall budget that is taken from general taxation* (Interviewee 2.5 Public Health Expert).

The distribution to the regions is calculated via formulas whose goal it is to ensure coverage, including primary care, hospital care and community-health services. The formula takes into account the age structure and health needs of the region's population when determining the allocation of funds (Ferré et al., 2014).

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[37] A ticket is a small copayment per referral that is fixed by each region. The price of the ticket is calculated by considering household income or considering the value of the service prescribed in the referral (Cicchetti and Gasbarrini, 2016). Exemption from the ticket costs vary per region.

[38] Sicily, Sardina, Valle D'aosta, Friuli and Trentino are *Regiona statuto speciale,* or regions with a special statute.

> *The number of the population is element number one, the you know, the stratification of age is another element in part certain chronic conditions disease conditions are recently included in this calculation. Nevertheless they are always struggling different regional presidents in order of course to add the most convenient formula for them, in general the northern region receive a per capita expenditure that is higher and most of this is due to the average age. When they calculate the regional budgets before giving the budget to the region, they also take into account internal mobility (i.e., cross regional healthcare)* (Interviewee 2.5 Public Health Expert).

The most important point in calculating the funds received per region is not only how many people live in that particular region, but also how old those people are. "The older the people, the more money a region receives. Therefore, each region receives different funding amounts" (Interviewee 2.3 Health Official). "Politicians don't have a say on the amounts, it is a nation-wide criterion. Changing it would require a proposal presented by all regions, agreeing on the parameter that need corrections" (Interviewee 2.1 Health Official).

Regional health systems are financed in the following three ways: 1) value added tax (VAT) revenues, of which a percentage is put into the balancing the Fund, 2) the production tax (IRAP), which is a local tax on productive activities within a regional territory 3) a combination of minor things such as the percentage of personal income taxation (IRPEF), and a tax on gasoline consumption (Brenna, 2011). A regions own revenue sources cover almost 45% of regional expenditure, although there is still considerable variety amongst the regions. For example, in 2003, Lombardy had the highest fiscal capacity, with a coverage capacity for current expenditure of 69% against a value of 26% for Calabria, at the lowest end of the regional spectrum. If you added in VAT revenues, Lombardy would have reached 87% coverage and Calabria 51%. Once the regions passed through the equalization mechanism, the situation turns:

Calabria, because of sources from the balancing fund, is able to cover almost 91% of its healthcare needs, while Lombardy, who gets no extra funds, remains at 87% (Caruso, 2009).

The goal here is redistribution, trying to make the health allowances of regions "more equal". These thoughts however, fueled initial resentment from the North towards the South, sentiments PRR leaders and parties capitalized on.

Exceptions to the Rule

Piani di rientro or re-entry plans

There are two instances where healthcare financing does not run exactly as described above:

> *At the beginning of the millennium, in 2001 2002 and so on, most of the regions, not only in the south, most of the regions did not have a balanced budget. They thus received strict orders from Rome, in theory, to introduce more taxes or do something in order to balance the budget. While the deficits of most of the northern regions were you know limited, some of the southern Italian regions had huge deficits especially Campagna, that is the region of Naples, and Lazio, the region of Rome* (Interviewee 2.5 Public Health Expert).

To address the continuously increasing healthcare expenditures in Italy, the Italian government introduced a program for regions that were overspending. The creation of the 'financial recovery plans', or *Piani di Rientro* were designed within the Finance Law (311/2004) passed in 2005:

> *The central government could take over the regional government when it came to healthcare. If there was a very high deficit the Ministers of Health and the Economy and finance Ministers would enter into an agreement with individual regions imposing either very strict or soft rescheduling plans* (Interviewee 2.14 political sociologist).

The operational programs for the reorganization, redevelopment and strengthening of the regional health service are known as re-entry plans and contain both rebalancing measures of the disbursement profile of the essential levels of assistance (LEA) and measures to guarantee a

balanced health budget (Ministro della Salute, 2020). Actions taken to balance the budget are, for example, addressing structural determinants of costs as well as reorganizing areas of palliative care, prevention or laboratories (Cicchetti and Gasbarrini, 2016).

The State-Regions Agreements (Article 8, paragraph 6, of L 131/2003 in implementation of Article 120 of the Constitution) are agreements between the national government (the state), wherein the Ministry of Health, and the Ministry of Economic and Finance are the representatives, and the regions (Ministero dell'Economia e delle Finanze, 2020). The conditions of these agreements, the decrees and regulations passed change every three years. See (Ministero dell'Economia e delle Finanze, 2020) for specific details.

The important thing to know, however, is that within these agreements, both parties' set the level of funding by the NHS for the period of the agreement. They also define the rules for governing the health sector and the methods of verifying the obligations of the regions. If the regions do not achieve the objectives set out in the re-entry plans, the repayment plans continue, lasting three additional years. Table 10 below depicts the ten regions that have been subjected to the re-entry plans since their inception. The table also illustrates whether the regions have simply presented a repayment plan (RP) or if the failures in the implementation of the latter have also led to the implementation of a Commissioner (RPC). As is clearly visible, Lombardy and Veneto have never been subject to such measures.

Table 6.1 Regions subject to re-entry plans

Regione	*30/06/2007*	*30/06/2008*	*30/06/2009*	*30/06/2010*	*30/06/2011*	*30/06/2012*	*30/06/2013*	*30/06/2014*	*30/06/2015*	*30/06/2016*	*30/06/2017*
Piemonte					RP	RP	RP	RP	RP	RP	
Liguria	RP	RP	RP								
Lazio	RP	RPC	RPC	RPC	RPC	RPC	RPC	RPC	RPC	RPC	RPC
Abruzzo	RP	RP	RPC	RPC	RPC	RPC	RPC	RPC	RPC	RPC	RP
Molise	RP	RP	RP	RPC	RPC	RPC	RPC	RPC	RPC	RPC	RPC
Campania	RP	RP	RP	RPC	RPC	RPC	RPC	RPC	RPC	RPC	RPC
Puglia					RP	RP	RP	RP	RP	RP	RP
Calabria				RP	RPC	RPC	RPC	RPC	RPC	RPC	RPC
Sicilia		RP	RP	RP	RP	RP	RP	RP	RP	RP	RP
Sardegna		RP	RP								

Source: (Bordignon et al., 2019).

The regions with high health budget deficits typically have an unsustainable budget imbalance and present shortcomings in the provision of LEAs (mandate basket of care by the central government). This implies that they are not able to meet the quality indicators set forth by the national government. In addition, these regions often have very high levels of pharmaceutical expenditure that reach far beyond the parameters set within the legislation.

If the regions subjected to these re-entry plans do not abide by the agreement and thereby upholding the budget, “a commissioner from Rome comes and relieves the region of its healthcare autonomy” (Interviewee 2.5 Public Health Expert).

Regiona Statuto Speciale or Regions with a special statute

The second exception to the normal health financing rules in Italy pertains to the five regions that have a special statute. Sicily, Sardinia, Valle D'Aosta, Friuli and Trentino are "*Regiona statuto speciale*. This implies that these five regions function like Federal States. This means that the taxes collected in these regions do not go to Rome, rather they are kept in the regions and pay for healthcare directly. So, they have a different amount of money" (Interviewee 2.15 Health Economist).

Again, to clarify, neither Lombardy nor Veneto fall into these two exception categories, thus these rules do not apply. It is, however, important to mention that such regions exist, and they are subjected to different rules and conditions when thinking about healthcare financing.

Contrary to Austria, where health policies are made at a national level, within the Italian case, the subnational cases will likely be more telling with regards to what the PRR do in terms of healthcare policy. In addition, the healthcare models as were described above could have potentially been chosen based on the party in charge at the time.

The National Case: Italy

The parliamentary republic of Italy is the 4th most populous country in Europe with over 61 million inhabitants. According to the most recent OECD report, Italy has the 4th highest life expectancy in the world (OECD, 2019), but sees the largest internal differences of GDP/capita for health of any European country (Health Consumer Powerhouse, 2019). Over the last 25 years, the Italian National Health Service (NHS) has transformed from a centralized to a regionalized and semi-federalized system (see Pavolini & Vicarelli, 2012 and Lynch & Oliver, 2019 for more detailed information) wherein the 19 regions and two autonomous states (Vatican

City and San Moreno) provide universal health coverage. The central Italian government controls the distribution of tax revenue for healthcare and defines the essential levels of health services (ELS). While much of the health competencies have devolved to the regions, the goal of this chapter will be to identify health policies directly or indirectly passed by the populist radical right (PRR) Lega Nord (LN).

While the main policy areas prioritized by the Lega Nord (LN) have always been immigration and fiscal autonomy through either federalism, secessionism or devolution (Bull, 2011), there are instances when they attempt to frame health policies to fit into these realms. The LN has been in national government over the course of several different election periods: ’94, ’01-’05 and ’08-11 (Figure 1) wherein they participated in Berlusconi’s right-wing coalition government briefly in 1994, were in another Berlusconi led coalition from 2001 to 2006 and formed another coalition with Berlusconi’s People of Freedom party in 2008. During this time the healthcare system was plagued with efforts to contain public health spending. Naturally, this led to retrenchment measures in healthcare typical of Conservative governments. After a name change leading up to the 2018 elections, the Lega made their last appearance in government through a coalition with the populist, anti-establishment party Movimento 5 Stelle (M5S; 5 Star Movement). During this period, the party’s new leadership becomes apparent through increasing anti-scientific rhetoric coupled with indirect welfare chauvinistically motivated health policies.

The chapter will continue with a history of the Lega Nord establishing that it does belong to the populist radical right party family. Starting from 2001, when the LN was in government, the health policies (direct) or policies relating to or impacting health (indirect) passed and/or addressed will be looked at in detail. Then, a section on the corona pandemic and the PRR response to it will follow leading into the chapter’s conclusion.

History of the Lega Nord

Founded in 1991 by Umberto Bossi as a regionalist populist party (see Mazzoleni & Mueller, 2016; Spektorowski, 2003), the Lega Nord (LN; Northern League) was born out of the success of several regional leagues (Veneto, Lombardy, Piedmont, Liguria, Emilia-Romagna and Tuscany). At this time, the Lega Nord was considered a "a populist movement with protest and identitarian features" (Tarchi, 2008 pg 91) whose goal it was to protect the Northern region's economy and culture (Giordano, 2001b; Lega Nord, n.d.). Much support was garnered due to citizens increasing resentment of economic and political problems, which the party used to criticize the South for being lazy and profiting from the transfer of hard-earned Northern resources (Betz, 2001; Savelli, 1992). During this time, the LN focused primarily on two political issues: 1) the "northern question" (Diamanti, 1996), implying a break between the wealthy North and the much poorer south, and 2) increased regional power because of the increasingly corrupt political and institutional elites (Bulli & Tronconi, 2011).

The LN's evolution into a full-fledged PRR party can be observed in how it participated in government and what issues became most pressing for them. Always being part of the centre right coalition, Casa della Libertà (CDL; House of Freedom) led by media tycoon Silvio Berlusconi's Forza Italia, the Lega initially chose to concentrate its efforts on regional topics, specifically, advocating for the independence of the North and thus showing little presence on the national stage. By the time the party entered into its second coalition with Berlusconi's' Forza Italia in 2001, the LN began solidifying its national issues: anti-immigration, devolution through constitutional reform, protectionism and a strong aversion to the EU's (European Union) single currency (Albertazzi et al., 2011). At this point, the party took on more nativist and

authoritarian positions (Mudde, 2007; Norris, 2005) although not entirely dropping its enthnoregionalist (Spektorowski, 2003a) ideology. The party's success during this period can be attributed to its passage of both the Bossi–Fini immigration law and the Constitutional Reform bill (devolution). While both of these laws had their faults (see Albertazzi et al., 2011), they allowed the Lega to establish "issue ownership" (Albertazzi et al., 2011) through their proactive participation in government.

The third and final coalition with Berlusconi, now head of the Il Popolo della Libertà (PdL; The People of Freedom, came in 2008. By this time, the LN had become the oldest party in Italy's parliament (Albertazzi et al., 2018). Rather than dissipate or be consumed by other parties, as happened to many other Italian parties, the LN became a primary force within Italian politics (Biorcio 1999) because it was able to change and adapt its rhetoric thereby adjusting to the changing political situation in Italy. The two pillars of discourse and themes were still greater northern autonomy coupled with the immigration of people from outside the EU; but the rhetoric of the party started to intensify with slogans such as "Let's close our borders" and the number of policies that were passed increased. LN Minister of Interior Roberto Maroni saw to the passage of two very strict security packages, the first of which, Law n. 94, went into effect in August 2009 and the second became law in 2010. Both laws increased the barrier of entry for immigrants specifically tightening the controls on convenience marriages and allowed for citizens to patrol the streets to help fight crime (Brunazzo & Roux, 2013). In addition, the government implemented eight decrees that supported further devolution and federalism (see Brunazzo & Roux, 2013).

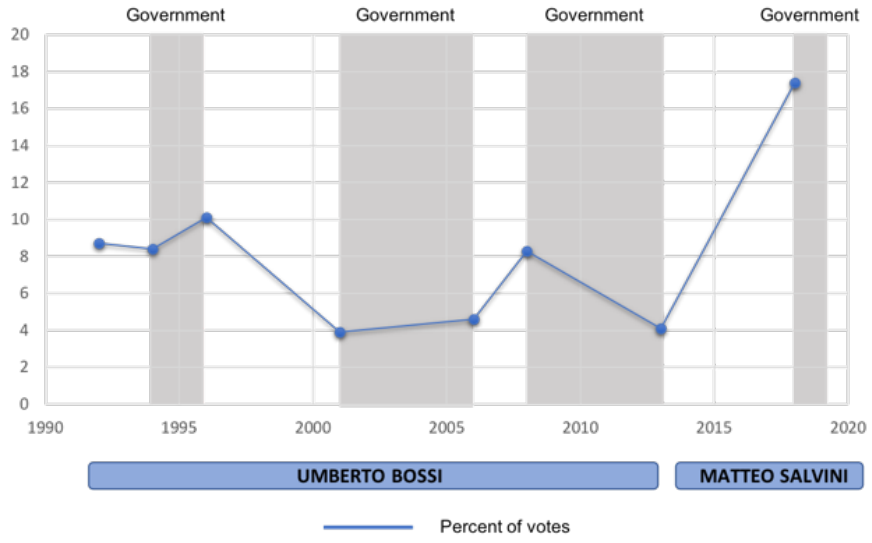
With the issues immigration, security and devolution at its core combined with the classic populist (Taggart, 2000) manner in which its leader, Umberto Bossi, justified its actions and

policies, the Lega Nord was in government three times - 1994, 2001, 2008 and becoming increasingly radical.

From Bossi to Salvini

After a corruption scandal, Bossi had to step down as the leader of the LN, handing the party over to Roberto Maroni in 2012. Maroni's leadership ended shortly after it begun as Matteo Salvini took hold of the party reigns in 2013 thereby moving the party even more to the right on the political spectrum.

Figure 12 General Elections (Chamber of Deputies) Results



Source (Governo italiano Ministero dell'interno, 2018).

According to scholars, Salvini's aim was to transform the LN from a regionalist party to one centred in anti-immigration and anti-EU policies, thereby following the sentiments of the population (Albertazzi, 2016; Brunazzo & Gilbert, 2017; Mancosu & Ladini, 2018). He went so far as to create a sister party to the LN known as "Noi con Salvini" (Us with Salvini) in 2014 in order to amass more support from the Southern regions (Perrone, 2018) and subtly dropped the

"Nord" from the party's name (Albertazzi et al., 2018), thereby officially putting an end to the Lega's regionalist ideology.

> *Lega, Lega nearly disappeared 10 years ago, now it is the strongest party, is the strongest party in Italy. What means? It means that its, its leadership has a, has a perfect understanding of what people want. On the contrary, social democrats are nearly disappearing, are, are inconsistent now. And the problem is that the leadership, of the left, of the social democrats are, are apparently unable to understand the will of the common people* (Interviewee 2.6 Medical and Public Health Expert).

Although Bossi had always proposed strict immigration policies (Brunazzo & Gilbert, 2017), Salvini took this a step further embracing the unconditional rejection of foreigners (Albertazzi et al., 2018) emphasizing the defence of the Italian people against external pressures such as the European Union (Caiani, 2019), and thereby appealing not only to neo-fascists but also to the many Italians fearing increased migration into the country. Both Bossi and Salvini are charismatic leaders, typical of populist parties; however, Salvini was able to increase his popularity, communication range and political influence through the use of social media (particularly through the use of Facebook and Twitter) (Albertazzi et al., 2018). While Bossi was most known for his alliance with Berlusconi, securing three government terms in a centre right coalition and his more conservative governing style (Brunazzo & Roux, 2013), Salvini shifted the Lega's direction towards radical right-wing populism (Brunazzo & Gilbert, 2017).

Salvini was increasingly successful because he understood that the Social Democrats failed to address the problems of the average man and woman.

> *That is one of the reasons why the Populists have such appeal. The appeal is that they are talking TO those people that are upset that they are being overheard and overlooked because they don't appear as intelligent as somebody that has a degree* (Interviewee 2.10 Public Health Expert).

Salvini, and in turn the Lega, found increased success because he was able to do what other parties could not – connect with the average Italian and make them feel understood.

PRR Lega?

While many scholars classify the Lega Nord, before Salvini (pre-2013), as PRR (H. Betz & Johnson, 2016; Ruzza, C. & Fella, 2009; Stefano & Ruzza, 2009; Verbeek & Zaslove, 2015; Zaslove, 2011), arguing that its ideology, political organization, and voter profile match other "third wave" PRR parties that emerged in the 1970s (Zaslove, 2011 pg 5-6); others disagree. Some state that while the LN was certainly always a populist party, its qualification as radical is more difficult to establish (Bartlett et al., 2012; Mudde, 2009). They argue that it does not meet the PRR criteria of having a nationalist, populist and authoritarian ideology and is instead nationalist, populist and regionalist with secessionist aims, an ethnoregionalist position, and a preference for decentralization (Zaslove, 2011). Others attest "If you want to talk about the Lega as a PRR party, start with its takeover by Salvini in 2012, before it was a regionalist RR party under Bossi" (Interviewee 2.11 Political Scientist) or "the current definition of PRR parties is more reflective of the Lega under Salvini" (Interviewee 2.13 Political Scientist).

For the purpose of this dissertation, I will follow the former logic that the Lega, although overwhelmingly regionalist pre Slavini, did fit into the original third wave categorization of PRR parties that emerged in the '70s. In the rest of this chapter, the health and social policies passed by the Lega or with the help of the Lega will be investigated starting in 2001. The parties first term in government will be left out because it was too short (six months).

It is also important to note that in addition to the Lega there are several Italian parties that have been interpreted as being PRR by scholars over the years. While some scholars include the

Alleanza Nazionale (AN; National Alliance) in the PRR family (Gómez-Reino & Llamazares, 2006; Norris, 2005), they provide no reasoning or justification for doing so. The AN, born out of the Movimento Sociale Italiano (MSI; Italian Social Movement) in 1995, had its roots in fascism (see Griffin, 1996), evolved into a modernization party 1998 – 2000 (Tarchi, 2003) and then settled into the position between the Forza Italia and the Lega on the political party spectrum, also identifiable as "proto-conservative party" (Ignazi, 2005) or "post-industrial far right" (Kopecek, 2007). In 2009, the AN as well as Berlusconi's Forza Italia merged into the newly formed Berlusconi led Il Popolo della Libertà (PdL; The People of Freedom). Currently, the AN is considered to be a part of the Fratelli d'Italia (FdI; Brothers of Italy), a former faction of the PdL.

The Fratelli d'Italia (FdI) can, since their founding in 2012, very much be classified as PRR (Gattinara & Froio, 2018) as it is a hard-right, nationalist, conservative and populist party that has origins in neo-fascism (Bruno & Downes, 2020). Although the party has never been in government, it is one worth looking out for in the coming years as it is gaining increasing momentum under the leadership of Giorgia Meloni (Bruno & Downes, 2020; Nadeau, 2018).

In addition to the PRR party family in Italy, there is also another type of Italian populism that has influenced the choices of the not only the Lega, but of other parties as well (Caiani & Padoan, 2020). The populist radical left led by the M5S is a relevant player in the Italian party system not only because the party has been in government over the course of two periods, but also because it has pushed for institutional reforms securing their biggest accomplishment through the 2020 referendum to reduce the size of parliament (Balmer & Fonte, 2020).

Health policies of the Lega

Berlusconi Government II & III (2001-2006)

The Italian Welfare state, including health and social policies, in the 2000s can best be described as an almost "frozen" (Naldini & Saraceno, 2008) landscape as all national healthcare reforms (decentralization, managed competition and different forms of privatization) took place in the 90's (Legislative Decrees no. 502/1992 and no. 517/1993); see Maino & Neri, 2011; Neri, 2019 for more detailed information. There was however an attempt by the centre-right Berlusconi coalition, fuelled by pressures from the LN, to dismantle some provisions of the constitutional health reforms (Constitutional Law no. 3/2001), such as those regulating doctors and managers in the public sector. The national government wanted to further increase opportunities for private sector involvement within the health care system at all levels, particularly in financing, through private health insurance. In addition, the LN presented a bill aimed at changing the constitutional reform approved just before the 2001 elections. According to the new proposal, the regions were supposed to be granted exclusive – instead of shared – legislative power in the health sector (Fargion, 2006). While decentralization continued, the proposed reform was rejected per referendum (LSE Health, 2006).

Between the years 2001 and 2006, Umberto Bossi (LN Minister of Institutional Reforms and Devolution) took on the task of introducing a stricter law on immigration; Roberto Castelli (LN Minister of Justice) promoted a controversial reform of the judicial system; and Roberto Maroni (LN Minister of Labour and Social Security) was at the forefront of efforts to restructure the pension system (Tarchi, 2008). The policies implemented by the Berlusconi government from 2001 and 2006 did not satisfy the voters as many of these policies turned out to be more moderate than those originally proposed by the LN. While the Bossi-Fini law introduced more stringent procedures for checking up on and expelling illegal foreigners by linking employment

to the ability to obtain a work permit or visa (Zaslove, 2004), it also led to the regularization of hundreds of thousands of immigrants already resident in the country (Albertazzi & Mcdonnell, 2008).

> *Okay, in the Bossi-Fini, I remember that there was a part of the law saying, if a physician accepts to treat a refugee, he can be legally persecuted, and he must denounce this person. The physician must call the authorities and be like... he's an immigrant. And there was a huge strike by physicians, a huge opposition which eventually led to a strike and the slogan was something like, "We are physicians, not police officers. We treat people, we don't care about where they're from." And that was possibly one of the biggest interferences with healthcare from Bossi-Fini. However, this part of the law was declared unconstitutional and therefore never enforced* (Interviewee 2.9 Medical Professional and Public Health Expert).

What happened instead was that regional governments provided health care for 650,000 regularized immigrants with no extra funding (Fargion, 2006). This reality was in stark contrast to the one presented in the LN pre-election manifesto, where the party asserted that immigrants would have to contribute to the national wealth before asserting the right to health insurance (Zaslove, 2004).

Compared to the previous centre-left government, the Berlusconi government had a different attitude toward operational agreements between public administrations and/or with representatives of the private sector. As it became clear with the publication of the White Paper on the Labour Market in October 2001, the centre-right government and, particularly, the Minister of Welfare, Roberto Maroni, wanted to create new forms of "social dialogue", wherein the role of the government and civil society would be more distinct, thereby also splitting the trade union front (Maino & Neri, 2011). The consensus of social actors would no longer be considered necessary in order to promote structural reforms (Maino & Neri, 2011). While it was very active in labour market and pension policies (see Laws no. 30/2003 and no. 243/2004 and

Ascoli & Pavolini, 2015), the Berlusconi government II and III did not promote any structural reforms in health care.

Berlusconi IV government 2008-2011

In 2009, the Berlusconi government began removing competencies for healthcare from the Ministry of Welfare transferring them instead to the Economic Ministry as cost-containment in the Italian NHS became the primary goal (Pavolini et al., 2015). This left the Health Minister, Ferruccio Fazio (Independent), with little to no powers to plan, coordinate and monitor regional health services. The result was cost containment programs that began in 2009 (Law Decree No. 39/2009) and 2010 (Law Decree No. 78/2010) and increased after 2011. These programs put spending caps on pharmaceutical expenditures, strictly controlled staff expenditures in public services (i.e., reducing the number of NHS employees, a suspension of collective bargaining and wage stagnation), increased patients co-payments, and decreased the expenditure allotted to purchase goods and services (Neri, 2019). In addition, while public spending for health stagnated at around 6.3% in terms of GDP and per capita expenditures, private health expenditure (predominately in the form of out-of-pocket-payments) as a percentage of total health expenditure significantly increased from 22.5% in 2007 to 25.8% by 2018 (OCPS Report, 2018). These measures cannot be specifically attributed to any party in government, rather they were a direct result of the economic and financial crisis and the subsequent controls the EU imposed on Italy due to its high debt (the relationship of GDP and public debt has been over 100% since the early 90's, surpassing 130% by 2014) and healthcare spending (Neri, 2019).

What can however be linked directly to the LN is the security package (Pacchetto Sicurezza) designed by Lega Minister of Interior, Roberto Maroni. This package was made up

five laws grouped together essentially characterizing immigrants as security risks (Meyer, 2015). While the package certainly contained several desperately needed revisions to security in Italy such as provisions making it easier to address crimes of human trafficking or increased collaboration with worldwide agencies (Maccanico, 2009), some articles (Law 94/2009, article 10 or Law 286/1998, article 35) impacted healthcare in a very negative way. The Pacchetto laws (or security package), as they are commonly known, most directly impacted the health of immigrant care workers (Meyer, 2015) (see Table 1). Article 10 made the status of being an undocumented immigrant a criminal offense and article 35 declared that undocumented immigrants could receive only emergency and essential medical care from the Italian National Health System. These laws had two different effects on immigrants: 1) Some immigrants felt scared deciding not to even come to Italy or the ones already in Italy decided to return to their home countries. 2) More experienced immigrants would simply ignore the laws knowing that they would continue to receive care. See Meyer, 2015 for the detailed interviews with immigrants regarding the security package.

By the end of 2011, the Berlusconi IV government was replaced by a technocratic government (Monti government) because international markets as well as the European Union no longer believed that the government could contain the countries debt. At this time the cost-containment programs increased and a spending review on public administration was put into place in 2012 (Law Decree No. 95/2012, converted into Law No. 131/2012) (Neri, 2019). Severe inequities, stemming primarily from geographic differences in health systems, in health status and health-care provision across the various Italian socioeconomic population groups resulted from these measures. Increased waiting times, and inequities in specialist care, favouring wealthier patients over poorer ones made access increasingly difficult (Ferré et al., 2014).

The LN's resume in government up until this point with regards to health can be seen as consistent with their coalition partners and the technocratic governments that replaced them. Governments across the board, whether technocratic, PRR or Conservative had the same approach to health – classic conservative cuts for the entire population. While the LN tried to mark some of their policies with a Liberal chauvinistic – cuts for all, but specifically for immigrants – characteristic, the general message was clear: public health expenditure was cut for all in order to adhere to the debt containment measures.

Conte I Government 2018-2019

At the general elections held in March 2018, the Lega gained over 17 per cent of the national vote – i.e., 7 per cent more than its previous best result in a general election back in 1996 (10.1 per cent) and secured its 4th term in a coalition government with the populist left M5S as a coalition partner (Albertazzi et al., 2018). During the election campaign, Salvini said that he and his party would put "Italians first" and that he would begin cracking down on illegal immigration, but he also had things to say in terms of health and health policy.

One of the first things M5S and Lega politicians did was prepare a proposal to eliminate the mandatory vaccinations for pre-school children (Lorenzin decree No. 73 of 2017) against 10 diseases including measles, tetanus and polio (Davenport, 2018) put forth by the centre left government in 2017. The new populist coalition argued that vaccinations benefited pharmaceutical companies (5SM) and claimed they could cause autism (Lega) (Harris & Monella, 2018). On the other hand, the coalition said that they were in favour of vaccines but were against coercion (Rezza, 2019) with the Lega insisting that the Lorenzin decree violated Article 2 of the Italian Constitution seeing as it opposed the freedom of care for minors (Casula

& Toth, 2018). Despite vehemently arguing to overturn the decree, this was never done. Instead, the government passed a measure allowing children to stay in school as long as their parents affirmed that they had been vaccinated; no proof was required (Horowitz, 2018). The problem with this decision was that already in 2017, the WHO reported a spike in measles cases due to misinformation about vaccines, with the greatest surges being in Europe and the Eastern Mediterranean regions (WHO, 2018), hence the Lorenzin decree. Mandatory vaccinations in countries with declining coverage, such as Italy, have proven to produce positive effects (Rezza, 2019), which is why members of the scientific community have doubts that the changes made to the Lorenzin decree were guided by scientific evidence (D'Ancona et al., 2019).

The next attack on the scientific community came in December 2018 only months after the new government was elected. Health Minister, Giulia Grillo, dismissed the entire health advisory board wanting to signal that this government would be doing things differently thereby discarding some of the biggest names in Italian medicine (Giuffrida, 2018). Political opponents presumed that the decision was made to suppress scientific opinions (Dyer, 2018). Shortly thereafter, Walter Riccardi, President of the Italian National Institute of Health and internationally recognized expert on vaccinations resigned stating "representatives of the government (by which he explicitly meant Salvini) have endorsed unscientific or frankly antiscientific positions on many issues" (Day, 2019 pg 1). In addition, Ricciardi claimed that this populist government was "playing politics with public health by pressuring health officials to adopt policies favorable to antimigrant views" (Day, 2019 pg 1).

In December 2018, the Decree-Law on Immigration and Security aka "Salvini Decree" (Corsi, 2019), pushed forth by Salvini came into effect (Law no. 132) as a modification of the previous Legislative Decree of 25 July 1998, n. 286 (see Table 1). Migrants had been accused of

exploiting the Italian welfare system and taking advantage of its services such as social housing and universal health care. Thus, the decree saw to it that not only the humanitarian protection status for migrants would be abolished, but it would also become easier to strip migrants of Italian citizenship, stops asylum seekers from accessing reception centres designed to combat social exclusion and generally weaken the public services available to them (Carlotti, 2020).

Anti-scientific rhetoric and actions were best displayed during this short-lived governmental coalition. No specific implemented health policies can be tied to the Lega during this time, however observations as to how the party dealt with health discussions and policy proposals point to a fundamental PRR characteristic, namely pursuing policies and making arguments without scientific evidence. In addition, the "Salvini Decree", although labelled as a security or immigration law, had profound effects on the health of undocumented migrants and continues to negatively impact public health throughout the corona pandemic.

Table 6.2 Lega Health Policies

PRR Health Policy	**Implemented**	**Coalition Partner**	**Outcome / Comments**	**Classification**
"Security Package" Law 94/2009, article 10 and modification to Law	Yes	Forza Italia	Article 10 made the status of being an undocumented immigrant a criminal offense and article 35 declared that undocumented immigrants could receive only emergency and essential medical care from	Welfare Chauvinism

286/1998, article 35			the Italian National Health System.	
"Salvini Decree" Law 132 (2018) modifying the Legislative Decree of 25 July 1998, n. 286	Yes	5 Star Movement	Abolish the humanitarian protection status for migrants, weakens the public services available to them	Welfare Chauvinism

Conclusion

The health policies passed or supported by Lega politicians can be summarized as being typically Conservative due to the strict debt containment measures during the Berlusconi coalitions (II-IV) and welfare chauvinistic coupled with anti-scientific rhetoric during the Conte government (I). While the LN was not in the position to directly pass health policies during the Berlusconi coalitions, they did support the retrenchment measures proposed during Berlusconi II. During the third Berlusconi government, the LN also supported further healthcare retrenchment efforts and attempted to reduce access to healthcare for undocumented migrants indirectly through the security laws.

During Conte I, the anti-scientific vaccination rhetoric and the welfare chauvinistic policies passed in the Salvini decree dominated the short-lived government. The already difficult situation surrounding the corona pandemic in Italy was made even more difficult due to the Lega's consistent criticism of the government, their attempt to uphold anti-immigrant sentiments by blaming migrants for importing the disease and their inconsistencies regarding the wearing of masks.

PRR politics in Italy, and elsewhere, can generally be summarized as having a lot of bark, but no bite. This was formulated more eloquently by Anna Cento Bull when she described the politics of the Lega as "a form of political communication that articulates demands which are not supposed to be taken seriously and implemented, but which are nevertheless constantly rearticulated" (Bull, 2010, 431). This is to say that manifestos and rhetoric are filled with action points, however when it comes to implementation policies, these can be counted on one hand. In fact, "policy proposals and even detailed legislative initiatives are made as mere instruments of political communication" (Ruzza, C. & Fella, 2009, 231-32). Put differently:

> *They don't touch healthcare, because that actually can have consequences and I don't think they know what to do about it. No one, literally, no one wants to be associated with certain decisions. Yeah, they don't even mention it because as I told you, regarding healthcare is way more important, the local politics compared to the central government* (Interviewee 2.9 Medical Professional and Public Health Expert).

Future research on the PRR in Italy should continue to follow the Lega, but also keep an eye open for Giorgia Meloni's Brothers of Italy. In addition, health policies in the country might be better studied on a regional level seeing as the devolution of the health system has left the national competencies rather sparse. The next task will engage in exactly this task: determining the health policies passed by the Lega on a regional level.

Chapter 7 **: The Subnational Cases of Italy**

This chapter is split into three sections. The first, somewhat loosely defined, section introduces the regional system in Italy. I begin by explaining regional politics very broadly focusing most specifically on the devolution of the Italian system. Then I move to the regional healthcare system describing the different models and what regions are responsible for in terms of health. Finally, to conclude section one of this chapter, I give. A high-level overview of the Lega Nord as the party pertains to the regions. The second section of this chapter focuses on the case of Lombardy, and the third section deals with the case of Veneto. A short conclusion will end Chapter 7.

Regional Politics

From a political perspective, every region in Italy has a statute that serves as a regional constitution, determining the form of government and the fundamental principles of the organization and the functioning of the region, as prescribed by Article 123 in the Constitution (Senato della Repubblica, n.d.). Five of Italy's 21 regions (Valle d'Aosta, Friuli-Venezia Giulia, Trentino-Alto Adige, Sicily, and Sardinia) have special financial and political autonomy (regioni a statuto speciale) (Bianchini, 1990). The fundamental difference between the two statuses is that while the ordinary statute is adopted and modified by regional law, the special statute is adopted by constitutional law (European Committee of the Regions, n.d.). This is essential when considering regional politics, party development, and healthcare financing, seeing as the regions with a special statute have greater legislative, administrative, and financial autonomy than the

other regions. However, because the two regions focused on in this dissertation are Lombardy and Veneto – neither fall into the special statute – the issue becomes important to realize but irrelevant for these cases.

What is, however, relevant is that the Lega Nord, with the help of Forza Italia, was key in giving regions more power (Kogan, 1975). Up until the 1970s, the Christian Democrats were consistently able to ignore the issue of regional autonomy. The issue of regional autonomy was not raised until the regions of Northern Italian expressed their discontent (which would eventually become the basis of the formation of the Lega Nord). Real legislative changes did not come until the 90s. The law 142/1990 surrounding the autonomy of local authorities marked the beginning of the devolution process. This structural reform was followed by the reformation of the accounting systems or local administrations (77/1995) and the "Bassannini Reform" (59/1997) that further decentralized the administrative powers of different governmental units (Calamai, 2009).

In 2001 the Constitutional Law 3/2001 of Title V of the Constitution was approved, devolving all subnational administrations. This culminating step in the devolution process gave the regions far more power, including almost unconstrained local revenue collection and grants from the central government that were not subjected to overbearing conditions. In addition, this change allowed regional presidents to not only hire and fire bureaucratic ministers at the regional level, but they were given much more power to create and enforce legal changes (Bull and Gilbert, 2001).

While this process of decentralization is now twenty years in the past, some people are wary of their actual allegiance:

> *Regions are a strange institution in Italy. They are supposed to be close to the territory, but my impression is that actually they are big institutions that are not very close to the people. It is much more a matter of lobbying to the national government. The regions have developed this function of doing a lot of lobbying and redistributing money, that's basically what they do. In some respects, there is a lot going on in terms of politics, much more than in terms of services and practices. The region is really a lobby kind of institution. They are much closer to Rome, and they are always trying to influence the national government, which is probably one of the reasons why the regions are losing popularity in Italy because you do not see the regional politicians around, they are in the shadows trying to deal with Rome and trying to get money and funding for their constituents. The regions are more active because the healthcare system is very much in the hands of the regions and the hospitals, and all the system are at the regional level* (Interviewee 2.13 Political Scientist).

While the quotation is more of a general statement directed at all regions, it would be interesting to see if my two cases (Lombardy and Veneto) also fit into this general description of being more loyal to Rome than their own constituents. But before jumping into the case of Lombardy, it necessary to take a closer look at how the regional healthcare system in Italy is structured and what it is responsible for.

Regional Healthcare System

The healthcare system in Italy changed in the 90s[39] , wherein the regions were granted more powers from both an institutional and an economic point of view (Cicchetti and Gasbarrini, 2016). Institutionally, they are tasked with creating the governance structure of the regional healthcare services. Economically they manage the national government's resources, which vary

[39] law n. 229/1999 is responsible for the devolution of healthcare to the regions and title V of the Constitution (D.Lgs.vo 56/2000) solidified this change (Atella et al., 2004).

based on the agreement reached between the regional health authorities, the Minister of Economics, and the Minister of Health.

It is important to note at this point that:

> *The national government doesn't choose the assessore alla sanita (essentially the regional health minister), nor the presidente della regions (President of the Region). These people are chosen every five years, and every region has its own schedule for that (they are not changed altogether, because some regions had problems in the past, their government fell, and this changed their timing as opposed to the other ones)* (Interviewee 2.1 Official for Health, Welfare and Sport).

In combination with the President of the Region and the Regional Health committees, Regional Health Ministers make the decisions regarding health in any given region. While the regions have to adhere to the general principles laid out by the national government, they can decide how to distribute resources and establish their own priorities and objectives in pursuit of health provision for their region. The regions have three important powers when it comes to healthcare. Firstly, they control the local health authorities (ASL – Azienda Sanitaria Locale), who plan and organize the population's health for each specific region. The ASL are divided according to districts within the regions, and these districts are responsible for the medical treatment, GP referrals, etc., of the people living within that district. In addition, the ASL's are responsible for guaranteeing the essential levels of assistance (LEAs). Secondly, the regions are responsible for appointing the healthcare agency's general managers. This is important because the criteria for both crediting and renumerating public and private suppliers are also handled at this level. Finally, the regions control the hospital authority (AO – Azienda Ospedaliera), a trust that manages one or more hospitals. In order to be considered an AO, the hospital must meet certain conditions laid out by the federal government. If the hospital does not meet these

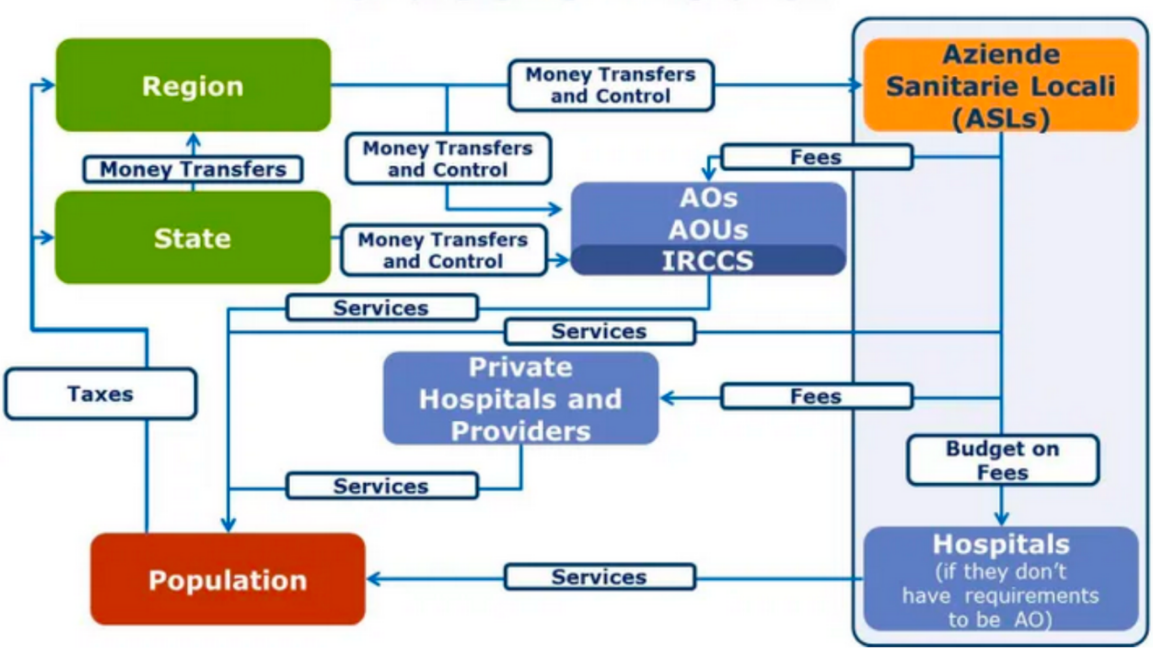
conditions, the hospital is placed under the control of the ASL in charge of the territory where the hospital is located.

With regards to hospitals, there are three other types aside from ASL controlled and AO's. The first is University Hospital Authorities (AOU), which are typically public and managed by university institutions. The second is Scientific Research Institutes (IRCCs - Istituto di Ricerca e Cura a Carattere Scientifico), which can provide public and private care. The final hospital option is simply the private hospital.

> *Regional systems are very different, as you know one from the other in terms of organization in terms of contracting out of services to the private actor to the private providers in terms of the division of the overall expenditure between hospital care and territorial health care and so on. So, in certain regions, we have many local authorities. In others, there are just a few; in some regions, for example, in Lombardia, there were many hospital trusts while there were none in other regions. So even from the organizational models, the various regions are different. And this is true starting from the beginning of the 90s* (Interviewee 2.5 Public Health Expert).

Over time four standard models of regional health services developed to reflect these differences. The first is the classic model (See Figure 13), initially implemented in all regions (except for Lombardy). Within this model, the ASL provides all health services. With regards to hospital care, the ASL assumes a double role: on the one hand, it provides hospital care through the hospitals under ASL control, and on the other, it funds all services that its patients receive from other hospitals (AOs, private hospitals, AOUs and IRCCs).

Figure 13 Classic Italian Healthcare Model



Source (Biselli, 2016).

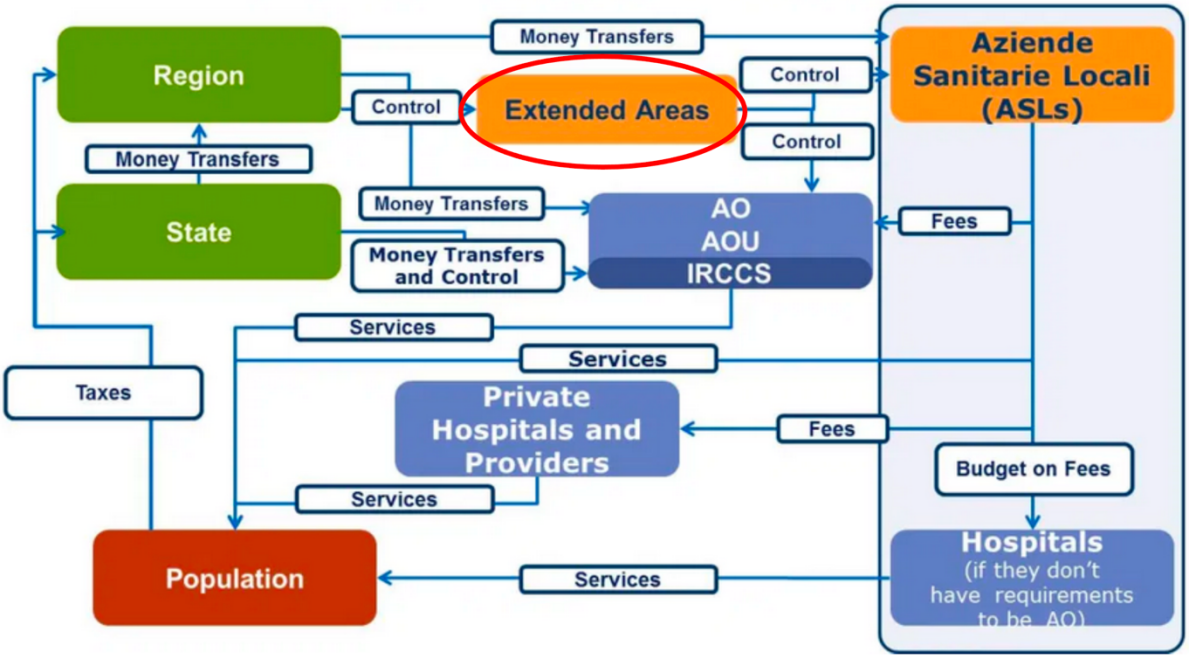
The second model is the Lombard model. The difference in this model is that ASL's do not control any hospitals and are therefore only in charge of providing health services. Thus, when looking at Figure 13, above, the relationship between the ASLs and the hospitals, on the very right, does not exist. Hospital services in this model are provided exclusively by AOs, private hospitals, AOUs, and IRCCs; however, the ASLs pay for the services provided.

The third model is used by the central Italian regions of Marche and Molise and generally works like the classic model. The major difference is the number of ASLs in the region. In this third model, there is only one ASL per region as opposed to numerous ASLs per territory. So, this model looks exactly like Figure 13, except it only has one ASL.

The final model known as the "Aree Vaste" Model is also similar to the classic model except that it has some intermediary authorities between the regional authorities and the ASL, namely the Aree Vaste (translated as "Extended Areas") See adapted Figure 14 below. Emilia

Romagna, Veneto, Tuscany, and Piedmont use this model. The Aree Vaste determines purchasing related to pharmaceuticals, medical devices, and non-medical goods; it is responsible for the logistics; information technology; financial administration; and human resources. The ASLs, on the other hand, are responsible for health services only in these regions.

Figure 14 Aree Vaste Model



Source (Biselli, 2016).

To summarize:

> *From the beginning of the mid-90s onward regional governments could decide their own healthcare organization models, we are talking about provision not financing, and they have chosen different models. And maybe it is interesting from the point of view the color of government to say that at least in the 90s, so in the first year of implementation of this regional autonomy, sometimes not always, but often, right-wing governments, we are talking about the alliance between Forza Italia, Berlusconi, AN and the Northern League, just in the north. So, the right-wing coalition prefer to be more open to private providers and emphasize the competition between public and private providers.* (Interviewee 2.5 Public Health Expert).

Put more simplistically: "In the case of Lombardy, the private sector has a very large role, while regions such as Emilia Romagna, Umbria, etc., the public sector plays a much greater role" (Interviewee 2.14 Political Sociologist).

Before jumping into the case of Lombardy, I find it important to also give a short overview of the Lega Nord, seeing as this is the most relevant party in my two cases.

The Lega Nord

The Lega, as described in the previous chapter, was created out of the Lega Nord (LN) or, as it was formally known, "*Lega Nord per l'Indipendenza della Padania*" (the Northern League for the Independence of Padania) in 1991. Padania, derived from the Latin Padus, refers to the territories bordering the Po River (Giordano, 1999). These regions originally included Lombardy, Veneto, Emilia-Romagna, Piedmont, Liguria, Friuli-Venezia Giulia, Trentino-Alto Adige, and the Aosta Valley. With the LN's *Declaration of Independence and Sovereignty of Padania* in 1996, the LN would add Tuscany, Marche, and Umbria to its "nations" (Lega Nord, 1996). However, the two most important regions were the Lega Lombarda in Lombardy and the Liga Veneta in Veneto (Giordano, 1999). The LN was born in Lombardy, and in both regions the party would consistently garner success allowing for its expansion across the North and then eventually throughout the country.

It is important to note that the Lega Nord had existed for a much more extended period of time at a subnational level than at a national level; in fact, the earliest mention of "Padania" was around 1945 by Gianfranco Miglio (Miglio, 1990). Miglio's work covers the period where these local movements had limited political impact. They were unable to offer a suitable alternative to the dominant Christian Democratic parties in the North between 1945 and the early 80s (Natale,

1991). Not until the Christian Democrats began losing touch with their Northern voter base did a position on the political spectrum open (Mannheimer, 1991). In 1982, the Lega Lombarda, headed by Umberto Bossi, was formed, soon to be followed by several other regional leagues (Liga Veneta, Lega Piedmont, etc.), and eventually uniting to form the Lega Nord.

Lombardy and Veneto are both part of what Arnaldo Bagnasco coined the "Third Italy" (Bagnasco, 1977). He described this area as being made up of specialized industrial districts located in small towns across the regions of Lombardy, Veneto, Friuli-Venezia Giulia, Emilia Romagna, the Marches, and Abruzzo. This contrasted the large industrial industries that dominated the North West (First Italy) and the industry sparse South (Second Italy)(Messina, 1998).

Focusing specifically on the "Third Italy", it is important to note that the Catholic and Christian Democrats (DC) in the Northeast (Lombardy, Veneto and Friuli-Venezia Giulia) and the Italian Communist Party (PCI) in the country's center (Emilia Romagna, the Marches, and Abruzzo) were the major political players in the area. The reason for this difference is because different actors (the church vs. trade unions) assisted the farmers during the agricultural crisis in the 1880s (Allum, 1985). With increased globalization and intensifying economic pressures that the late 80s early 90s brought with them, the "Catholic world" of the Northeast was no longer able to offer viable solutions to increasing unemployment and economic unrest. The LN, on the other hand, offered solutions to the struggling small businesses through alternative development conditions (Messina, 1998), thereby successfully replacing the DC as the dominant party in the region. One of the main solutions proposed by these regional leagues, specifically the Lega Lombarda, was decentralized politics. Regionalism and the push for decentralization responded

to the failures of nation-state politics to combat corruption and provide satisfactory public services (Ruzza and Schmidtke, 1993).

Lombardy

This section will begin with a political overview of the region, followed by an in-depth view of the region's healthcare system. Then, I will look at the impact that the Lega had on this region's health policies.

The Politics of Lombardy

The region of Lombardy is located in the far north of the country, surrounded by the regions Trento Alto-Adige and Veneto on the East and Piedmont on the West. Lombardy is a representative democracy, where the President of the Region (*Presidente della Regione*) is the head of government. The President of the Region is elected directly by the people every five year. In general, as defined by Article 121 of the Constitution, s/he "represents the Region, directs the policymaking of the Executive and is responsible for it, promulgates laws and regional statutes, directs the administrative functions delegated to the Region by the State, in conformity with the instructions of the Government of the Republic" (Senato della Repubblica, n.d.). More specifically, however, the duties and role of the President are defined by the Statute in force in each region. In the case of Lombardy, there are no additional functions that the President assumes. The President of the Region is also the Regional Health Authority and thus issues decrees for the entire territory or for part of the territory in the case of emergency. See Table 12 below for an overview since 2000.

Table 7.1 Presidents of the Region in Lombardy

President of the Region	Party	Year
Roberto Formigoni	Forza Italia & Il Popolo della Libertà	1995 - 2010
Roberto Maroni	Lega Nord	2010 - 2013

Attilio Fontana	Lega	2013 - Present

The executive power is found within the Regional Government (*Giunta Regionale*). The regional government functions through resolutions adopted by a majority of its members, such as bills and administrative acts within the competence of the Regional Council. The President of the Region can approve regional regulations, except for those delegated by the national government. See Tables 13-17 for some of the most important (for my dissertation) ministries and which party held them.

Table 7.2 Regional Government Fontana XI (2018- 2023).

Name	Party	Position
Attilio Fontana	Lega - Lega Lombarda	President
Davide Carlo Caparini	Lega - Lega Lombarda	Budget Councilor
Stefano Bolognini	Lega - Lega Lombarda	Councilor for Social, Housing and Disability
Giulio Gallera	Forza Italia	Councilor for Health and Welfare
Alessandro Mattinzoli	Forza Italia	Councilor for Economic Development

Table 7.3 Regional Government Maroni X (2013- 2018)

Name	Party	Position
Roberto Maroni	Lega Nord	President
Mario Mantovani	Il Popolo della Libertà (for Forza Italia)	Vice President responsible for Health and the EU
Maria Cristina Cantù	Lega Nord	Councilor for Family, Social Solidarity and Volunteering
Cristina Cappellini	Lega Nord	Councilor for Culture, Identity and Autonomy
Massimo Garavaglia	Lega Nord	Councilor for Budget, Economy and Simplification

Table 7.4 Regional Government Formigoni IX (2010- 2013)

Name	Party	Position
Roberto Formigoni	Forza Italia	President
Mario Malezzini		Councilor for Health (2012-2013)
Luciano Bresciani	Lega Nord	Councilor for Health (2007-2012)

Table 7.5 Regional Government Formigoni VIII (2005- 2010)

Name	Party	Position
Roberto Formigoni	Forza Italia	President
Alessandro C'è	Lega Nord	Councilor for Health (2005-2007)
Luciano Bresciani	Lega Nord	Councilor for Health (2007-2012)

Table 7.6 Regional Government Formigoni VII (2000- 2005)

Name	Party	Position
Roberto Formigoni	Forza Italia	President
Milena Bertani		Councilor for Health

The legislative power is vested in the Regional Council (*Consiglio Regionale*). This council was established in 1970 and currently consists of 80 seats, including the President of the Region. See Table 18 for an overview of how many seats the majority party had starting in 2000.

Table 7.7 Majority Party in Lombardy

Election Year	Majority Party and Seats out of 80*
2000	FI 27
	LN 11
2005	FI 25
	LN 15
2010	PdL 29
	LN 20
2013 *snap election*	PdL 19
	LN 16
2018	LN 29
	FI 14

Source (la Repubblica, n.d.).
*Only the top two parties were chosen from the majority coalition.
FI ➔ Forza Italia
LN ➔ Lega Nord
PdL ➔ The People of Freedom

From Lega Lombarda to Lega Nord

The Lega Autonomista Lombarda (more commonly known as the Lega Lombarda or LL) was created in 1984, just a few years after the Liga Veneto, by founder Umberto Bossi. In its first appearance at the general election in Lombardy, the LL gained 2.6% of the votes in the region.

Similar to the motivations behind the Liga Veneto, and all other Leagues, the original focus of the LL was on autonomy and problems of corruption and taxation. According to an interview conducted by Benito Giordano with an LL official, “the Lega was born out of problems stemming from taxes. They continually increased during this time” (Giordano, 1999).

The rise of the LL and thus the Lega Nord's strength can best be explained by looking at the province of Varese in Northern Lombardy, close to the border of Switzerland. In the late 80s early 90s, Varese was an industrial area known for manufacturing, textiles, and especially its foot ware industry, making it one of the wealthiest in all of Italy (Giordano, 1999). According to Benito Giordano's interviews with the politicians of Varese in the 90s, the people of the province became increasingly aggravated by the fact that they were paying high taxes and were receiving poor public services in return (Giordano, 1999). The LL used this opportunity to enter the political spectrum by giving the people of Varese an outlet to blame, namely the central government and the Southerners. The LL criticized the central government and the Christian Democrats (as the representing party) for being unable to provide the province with adequate public services. At the same time, they accused the Southerners of receiving too much governmental support based on Northern taxes.

In 1991, the LL took charge of federating all the regional leagues into the Lega Nord (LN), thereby endorsing greater autonomy for Northern Italian regions while simultaneously rejecting the bureaucracy and corruption surrounding the national government (Maraffi, 1994). There were six regional movements from the North, including the Lega Lombarda, Liga Veneta, Piemont Autonomista (all entho-regionalist movements), and the Union Ligure, Lega Emiliano-Romagnola, Alleanza Toscana, who were more recently established and primarily supported by the LL. Shortly after this union of the six regional parties, two addition regional parties from

Trentino and Friuli-Venezia-Giulia joined what would become better known as the Lega Nord. What united these regional parties was the longing for cultural, political, and economic independence based on the community's interests (Ruzza and Schmidtke, 1991; Stacul, 2003a).

Varese is also important because it was the birthplace of the Lega Lombarda (LL), and thus the Lega Nord (LN), as well as party leader Umberto Bossi. The commune of Varese was the first to elect an LN mayor, and the province of Varese was the first to elect an LN President (Giordano, 1999). This trend continued at a national level as well with the election of Bossi as senator in parliament in 1987. By December 1990, the regional elections showed that the previously dominant Christian Democratic party's (CD) vote share decreased to 28.6% from 36.03% in 1985, while the LL was able to increase its share to from .46% in 1985 to 18.94% in 1990 (Dipartimento per gli Affari Interni e Territoriali, 1992). See Figure 15 below for a visual of the creation of the LN after 1990 and the complete disappearance of the DC. The LN replaced the Christian Democrats and were now seen as the protectors of the local, small business model (this was particularly relevant in the North East – see Veneto case) and community life, both of which seemingly disappeared with the disintegration of the nation-state (Stacul, 2003a). Ethnic criteria were defined to recreate a sense of community sheltered by the LN. These criteria were not based on language, rather by territory, thereby creating the 'Northern identity' (Stacul, 2003a).

The political appeal of the LN was much different than for other PRR parties as it was not based on ethnic or cultural factors (Vampa, 2016b). Instead, the LN stressed that Lombardy and the other Northern regions were the wealthiest in Italy and that their wealth was being used to subsidies the poorer and "lazy" Southern regions. The party went so far as to invent an

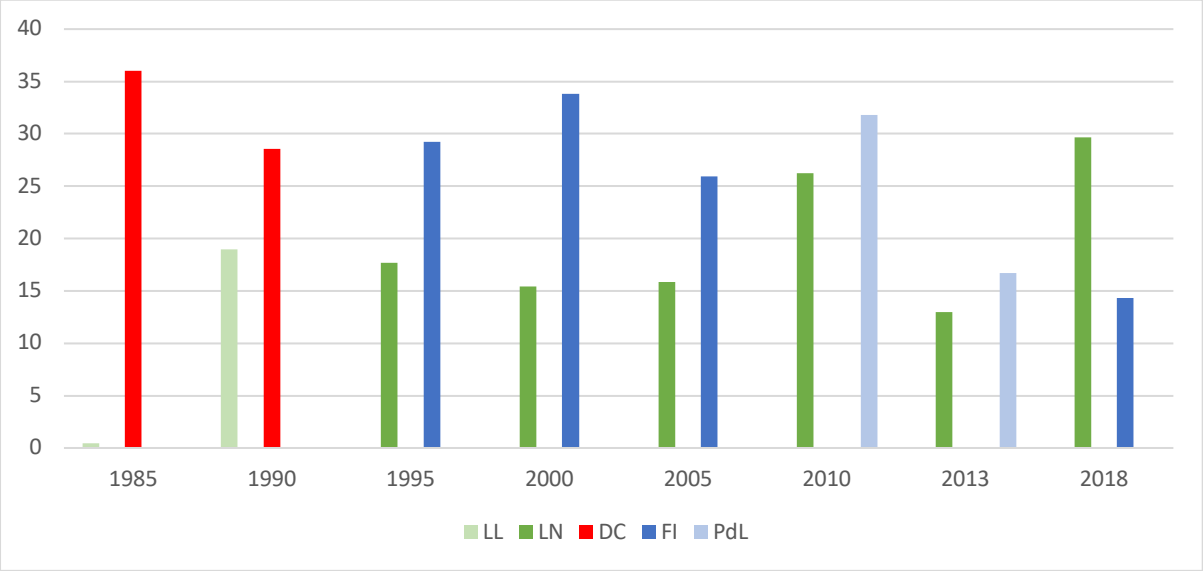
ethnicity based on strong localisms, a culture of hard work, free-market values, self-enrichment as well as ingrained racism towards Southerners and immigrants (Ginsborg, 1996).

The LN, however, was not the only party that occupied the ideological space of neoliberalism, anti-statism, and fiscal protest (Ignazi, 2005). Silvio Berlusconi's Forza Italia (FI), created in the mid 1990's offered voters similar views, although FI was not bound to the North as was the LN at the time. So, while the LN movement LN was

> *created by Umberto Bossi, it remained a very local one. The one who really made the movement acceptable on a national scale was Berlusconi. Berlusconi in the 90s made alliance with the AN (hard right post-fascist, comparable with FdI now) and the Lega. Berlusconi made these "people" acceptable, to make these parties voteable and acceptable to parliament. So, even if we now consider Berlusconi to be moderate compared to these other two parties, at the end of the day, we should never forget that he was the first that really gave these parties a platform and cleaned them up somehow* (Interviewee 2.16 Political Geographer).

Because of the similarities between FI and LN along with the Alleanza Nationale (AN), they formed a coalition. This coalition has led the region of Lombardy since 1995 and promotes a region-specific model of welfare in Lombardy (Vampa, 2016b).

Figure 15 Percentage of votes won in the regional election



Note: the light green bars represent the LL, while the dark green bars represent the LN.

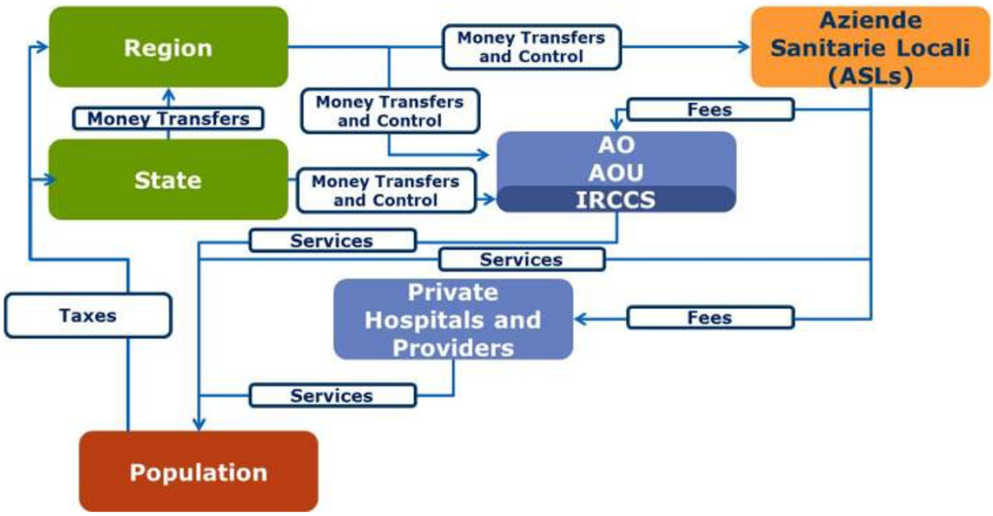
The Lombard Healthcare Model

Upon the Italian healthcare reform in 90s (decrees 502/92 and 517/93), where the national government decided to decentralize healthcare leaving it up to the regions how they wanted to spend public money, Lombardy, at that time under the leadership of Roberto Formigoni (FI) took a different route than the other regions (regional law 31/1997). While most regions continued to use the central government's reimbursement rates and quality standards, Lombardy passed the regional law 31/1997 and set up a quasi-market model (Brenna, 2011).

The regional law saw an increase in quality standards, set its own reimbursement rates, and made public and private hospitals each eligible for public funds (Ferré et al., 2014). In addition, all hospital and specialist services were delivered by either hospitals or private providers (Cicchetti and Gasbarrini, 2016). If a hospital, whether public or private, meet the quality standards and charges for the agreed upon reimbursement rate, it would qualify for public funds. Therefore, patients in Lombardy are free to choose between public or private hospitals without being subject to extra costs; their co-pay would remain the same in either case. The benefits of a system with such competition (Stancati, 2010) are threefold: 1) the quality of services are improved, and (Colombo, 2008), 2) the variety of the services are increased (Colombo, 2008), and 3) it is a good way to control health expenditures, meaning the system is efficient (Brenna, 2011). The unique thing about Lombardy is that it does not have a Regional Health Agency (RHA) by choice. There is, however, a regional epidemiological observatory that performs some of the functions of the RHA (Mapelli, 2007). To get a better sense of these differences, see Figure 17 below.

As mentioned at the beginning of this chapter, the difference between the Lombard model and the classic model is that ASL's do not control any hospitals and are therefore only in charge of providing health services. Hospital services in this model are provided exclusively by AOs, private hospitals, AOUs, and IRCCs; however, the ASLs pay for the services provided.

Figure 16 Lombard Health System Model



The system has 15 Local Health Units (ASL) organized in 86 Districts. The region raises and manages funds for healthcare and then plans activities in cooperation with ASLs. While the ASLs manage the healthcare on the provincial level, smaller units known as Districts are responsible for care within their areas. The Districts not only manage the primary and ambulatory care but are also responsible for the residential care of a given area (Brenna, 2011).

> *From the patient's point of view, the difference between for example the regional Emilia Romagna model and the Lombardy model is the freedom of choice. So, in Lombardy, they pay the same, but they have a wider freedom of choice as they can choose freely between public and private providers. So, the idea is that they do not pay more and just choose between the different public and private facilities. While in Lombardy, the philosophy was all the private providers can be chosen. So it was, you know, wider the freedom of choice. But in terms of what was given to the patients, there were no differences in*

> *terms of the rights the service provided and even the waiting times* (Interviewee 2.5 Public Health Expert).

This implies that the while the patients in Lombardy patients are able to freely choose between private and public facilities without extra costs, the services provided in those facilities are exactly the same in a region like Emilia Romagna, where private facilities can only be freely used if contracted by the region (naturally there are not many of these).

Criticisms of the quasi-market model refer to cream-skimming, cherry-picking, voluntary up-coding, and skimping (Anessi-Pessina et al., 2004; Berta et al., 2009; Fattore, 2019; Jones and Cullis, 1996). Other points to consider are relatively high out of pocket costs for financing the healthcare system (Universita Bocconi, 2017) as well as the fact that the model is too hospital oriented (see chapter 8 on COVID-19), general practitioners are typically not seen as a valued doctor, and their role of addressing the patient pathway is largely ignored (Colombo and Parisi, 2019). Put differently,

> *Lombardy invested its money in the hospital network. This division of labor has led to less bargaining power for those who organize care, overloaded hospitals with work and reduced the activities of professionals outside the hospital, damaging continuity of care* (Interviewee 2.19 Medical Professional).

While there might have been advantages of a hospital centric system in the early 90's, it seems that the disadvantages of such a system began increasingly apparent over time – culminating the corona pandemic (See Chapter 8).

The Lega and Health

Roberto Formigoni (FI), President of the Region from 1995 until 2013, is important to discuss despite the fact that he does not belong to the Lega party. According to (Gori 2010),

Formigoni, and thus FI, along with the regional health council, was responsible for adopting the Lombard regional health model (previously described). This very hospital centric model considered "GP's useless under Formigoni and even under the Lega" (Interviewee 2.17 Economic Sociologist and Social Policy Expert). Formigoni adopted this new model on the basis of the subsidiary principle (the sharing of competencies between public and private actors see Groppi and Scattone, 2006). Not only did Formigoni and the Forza Italia party as a whole play an important role in this transformation, but catholic interest and business groups were also brought on board to solidify the quasi-market model (Vampa, 2016b) What is important to understand is that:

> *The President of Lombardy for almost 20 years, Formigoni, came directly from their (Comunione e Liberazione) ranks. So, what Formigoni did for 20 years, was practically occupy the healthcare system in Lombardy. So, it means that every time they had to substitute someone like... I don't know... the head of departments of surgery or whatever, they tried as much as they could to put their own people in, people loyal to the traditional Catholic Church* (Interviewee 2.17 Economic Sociologist and Social Policy Expert).

The involvement of the catholic church in the Lombard healthcare system made it even more unique. For example, in Lombardy, "you could not become, or you were not able to become a doctor in Gynecology if you were not supported by the Catholic's" and it was really difficult at the time to "use your right of abortion because most doctors did not allow it" (Interviewee 2.17 Economic Sociologist and Social Policy Expert). Furthermore,

> *They (the Lombard government led by Formigoni) opted for a very different framework, where the private sector had the upper hand over the public. So actually the main structures in Lombardy are from private systems, San Raffaele, San Raffaele hospital, San Donato hospital. If you look at the name, you, you may have an explanation for these choices, because if you look all the hospital, all the private hospital in Italy are named after a Saint: San Donato, San Raffaele because the majority of the, of the, of the hospitals in Italy were originally founded by the Catholic Church* (Interviewee 2.6 Medical and Public Health Expert).

During the Formigoni presidency (1995-2013), welfare (specifically health) was also heavily associated with the freedom of choice and the will of the market (Pavolini, 2008). In addition, "the provision of health services, both in hospital and in the community setting, depended solely on hospitals" (Interviewee 2.18 Medical Professional and Public Health Expert), implying that the system was hospital centric. This association did not change when the Lega took over in 2013. Although Roberto Maroni (LN 2013-2018) recognized and attempted to change the imbalances of the system he, as well as his successor Attilio Fontana (2018 – present) were unable to change the existing market-based model.

Not only did the Lombard model heavily rely on the free market principle, but it was also constructed so that "matters could (and should) be handled by the lowest, or closest possible level to where they will have their effect" (Colombo, 2008, p182). This principle made itself clearly visible as the regional government opted to control only the regulating, programming, and financing, while the management and delivery of healthcare and other welfare services were left to the provinces and municipalities. This principle of "hands off" governing was coupled with the desire that citizens should be given the maximum amount of freedom to choose providers for their required services.

What is interesting to note in the healthcare governing principle in Lombardy is that while the new healthcare model was constructed around the concept of 'horizontal subsidiarity' between public and private sectors, the Lombard government itself preferred a more vertical governing system. The horizontal system most readily applied to hospital competition in the region, implying that both the public and private sectors were equal players and had to compete for resources. The vertical system, or hierarchical system as it is more commonly known, that the

Lombard government assumed saw to it that sub-regional, provincial authorities were seen as rather passive executors of decisions made by the regional institutions (Pavolini, 2008, p 175). In addition, the regional government opted against a formalized system of institutional bargaining with social partners and left this to the municipal level. It was usually provincial leaders from centrist or center left-leaning parties that bargained with social partners (Regalia and Colombo, 2011). This implied that national centralism was replaced by regional centralism, which is exactly the vision of governance supported by the Lega Nord (Stacul, 2003b). The Lega Nord saw regional institutions as the most important for political action to push against Rome's central pressures and the provincial demands of the center-left coalitions (Vampa, 2016b). As can be observed in Table 19 below, while the regional government of Lombardy has been consistently in the hands of the center-right or the PRR, the mayors are predominately of the center-left (i.e., Democratic Party – PD), thus it was in the center-right, and later, the Lega's best interest to support regional centrism.

Table 7.8 Lombardy: Provinces, Mayors, and the Parties they are associated with

Province	Mayor (since)	Party
Milan	Giuseppe Sala (2016)	Independent (close to PD)
Varese	Davide Galimberti (2016)	Democratic Party (PD)
Monza Brianza	Dario Allevi (2017)	Forza Italia (FI)
Brescia	Emilio Del Bono (2013)	Democratic Party (PD)
Como	Mario Landriscina (2017)	Independent (Center Left)
Bergamo	Giorgio Gori (2014)	Democratic Party (PD)
Pavia	Fabrizio Facassi (2019)	Lega
Mantova	Mattia Palazzi (2015)	Democratic Party (PD)
Cremona	Gianluca Galimberti (2014)	Democratic Party (PD)
Lecco	Mauro Gattinoni (2020)	Independent
Lodi	Sara Casanova (2017)	Lega
Sondrio	Marco Scaramellini (2018)	Lega

Starting in 2005, the LN almost constantly controlled the regional health department (Vampa, 2016b). In 2005, Alessandro Cè (LN) became Councilor of Health and controlled the regional department of health, thereby marking the LN's increasing strength as a coalition partner in the center-right Formigoni government. However, because Formigoni played such a strong role within the health sector, Cè's opinions matter little and "practically crushed by Formigoni" (Interviewee 2.17 Economic Sociologist and Social Policy Expert).

In 2007, Cè left the party stating that the Lega only "served the interest of the strong powers (Forza Italia)" and that these powers were "very interested in the board of directors, but less so in the interests of the people." He continued his criticism stating that "the League was born against the excessive power of the parties, now it has become like the others" (Riosa, 2007). In Cè's opinion, the LN's coalition with FI was "absolutely negative" as the FI was too "attentive to the interests of the corporations, lobbies, and clienteles. For the Lega, it is a mortal embrace" (Riosa, 2007). Heart surgeon Luciano Bresciani (LN) replaced Cè in the fall of 2007. In 2012, Bresciani stepped down after a fraud investigation (involving President Formigoni) regarding bribes paid to a medical supply company (Redazione, 2014). These accusations eventually also led to the resignation of Formigoni, who Roberto Maroni then replaced in 2013.

In sum, the LN's role in healthcare at this time was essentially appeasing Formigoni. Formigoni included the Lega in his government, very similarly to Berlusconi on the national level, and made the party more acceptable to voters by toning down some of their rhetoric (Vampa, 2016b). Because there no significant changes to the Lombard welfare system had even been suggested since its inception through Formigoni, it appears that the LN was either also a strong promoter of the quasi-market and has not been willing to drastically change it (Vampa, 2016) or simply did not have the political power to change anything.

Roberto Maroni (2013 – 2018)

Upon becoming the President of Lombardy in 2013, Roberto Maroni (Lega) highlighted the continued importance of supporting a regional healthcare system based on the freedom of choice. However, Maroni attempted to modify the system to make it more integrated and less hospital based:

> *The healthcare reform approved by Maroni in 2015, and following reforms, tried in some ways to change some elements of the Lombardy Healthcare system especially what they tried to do was to bring more integration. Because this, the quasimarket system implemented by Formigoni, had given great priority to the hospital care. And so, there was awareness of this, the need to rebalance the system, and in some ways, Maroni reform tried to do it, but they were unable to do this balance* (Interviewee 2.21 Economic Sociologist and Social Policy Expert).

In 2015, the law 23/2015 not only promised to enhance the social welfare aspect of the healthcare model by increasing support for community welfare, but it also rebuilt the local structure of governance to decrease institutional fragmentation. In essence, the goal was to centralize the region in certain aspects. In addition, the Maroni government introduced a new "autonomous income" (reddito di autonomia) in 2015, which was specifically created to support the more disadvantaged sectors of society (the unemployed, elderly and disabled) (Vampa, 2016b). The autonomous income plan was designed with civil society's help, most notably the Caritas Ambrosiana, the trade unions, and some voluntary associations (Guidetti, 2016). Researchers commented on the income package in a short volume, concluding that it "seemed to offer a package of categorical, episodic and non-structural actions with a strong welfare stamp" (Dessi, 2016, p4).

Table 7.9 Regional Laws and Resolutions

Law / Resolution	**Impact**

Regional Law no. 23 / 2015	Evolution of the Lombardy health and social system - territorial social and health care reform
Resolution no. X / 4662 of 23 December 2015	Regional guidelines for the management of chronicity and fragility in Lombardy 2016-2018
Resolution no. X / 5117 of 29 April 2016	Regional guidelines for the adoption of strategic business organization plans of the health protection agencies
Resolution no. X / 6164 of 30 January 2017	Start of the treatment of chronic and fragile patients
Regional law n. 6 of 3 March 2017	Evolution of the Lombard social and health system
Resolution no. X / 6551 of 4 May 2017	Reorganization of the supply network and methods of taking care of chronic or frail patients

Source: (Senato della Repubblica, 2017).

Criticisms of the 2015 law came from the central government. The brief (Senato della Repubblica, 2017) explained that with the resolutions X/5117 and X/6164 (see Table 20 above), Lombardy was completely modifying healthcare by replacing some of the founding pillars of the health reform law no. 833 of 1978 through the attempt to privatize public care for the chronically ill. With these resolutions, Lombardy divided the "chronic and fragile patients" into three levels according to the severity of their clinical condition and would receive letters through which the region would invite them to choose a "manager" to whom to entrust, through a "pact of care," one's own health. This manager could be recommended to them by their general practitioner or chosen independently from a specific list. Basically, what it comes down to is that a manager and a company would replace a general practitioner's role.

While this reform was initially seen as improving the situation for this societal group, as mentioned above, the brief found that it would likely lead to the reduction of health benefits of millions of citizens in the long run. By driving the elderly and chronically ill into the hands of private healthcare, the reform is aimed at privatizing the assistance of the chronically ill (Senato della Repubblica, 2017). So, what ended up happening was, "many health needs were left uncovered and the links with the local stakeholders were cut. In addition, the reform was never

fully applied in cultural and organizational terms" (Interviewee 2.18 Medical Professional and Public Health Expert).

Another action point supported by the Maroni government was the regional resolution (7631/2017). Herein, the territorial borders of the Area Social Plan (Piano di Zona) responsible for social services would be given greater financial compensation in order to be able to provide innovative answers to newer and more complex social needs whilst also improving the working relationship between the social and healthcare systems (see (Previtali and Salvati, 2019) for more detailed information regarding the Area Social Plans). Essentially, this further decentralized social services in order to strengthen the relationship between all actors at the municipal level.

A final action point worth mentioning about the Maroni government is that Roberto Maroni threatened to cut regional transfers to municipalities that hosted refugees (Vampa, 2016a). In an open letter to the municipalities, Maroni stated the following:

> *I decided to write a letter to the Prefects to warn them about bringing new illegal immigrants here to Lombardy. I also decided to write to the mayors to tell them to refuse to take them. If mayors accept them, we will reduce regional transfers as a disincentive because they do not have to. Whoever accepts illegal immigrants is violating the law and will suffer this consequence* (la Repubblica, 2015).

These words were supported by the President of Veneto, Luca Zaia, who backed up Maroni, stating that "we are mad at the inadequate government that, in official documents, invites us to manage the 'acute phase' of immigration. When we all know that it is not acute, it is chronic" (la Repubblica, 2015). Zaia continued to argue that Veneto, along with Lombardy, have thousands of regular migrants wherein many of them do not have jobs, and thus he believes the northern regions are helping enough. Much backlash came from other regions, especially those of the south accusing Lombardy of using Mafia methods to threaten its municipalities. A further example of Maroni's attempt to centralize the power of the region can be seen here.

There appeared to be three reasons for the changes brought forth by the Maroni government: 1) the government recognized that the overwhelming hospital-centric healthcare system would no longer be able to address new healthcare challenges (Salvati, 2018); 2) the increasing economic pressure caused by both the economic crisis of 2015 leading to increasing health expenditure costs; and 3) increased migration.

While Maroni certainly made changes to the healthcare system during his time as President, he never strayed far from the original principles set forth by Formigoni.

Attilio Fontana (2018 - Present)

Attilio Fontana, a lawyer, was the mayor of Varese (the Lega stronghold in Lombardy, as mentioned in Chapter 6) before becoming the President of Lombardy in 2018. Politically, Fontana has very close ties with Roberto Maroni and Giancarlo Giorgetti, both big Lega names and Varese residents (Rotondo, 2018). Put a bit differently and more in context of the COVID-19 pandemic:

> *Fontana is very much connected to the central party, to Salvini, because he (and Giulio Gallera) were not so strong by themselves. They needed the central party to help them get the positions they got. They weren't strong and still are not strong, particularly considering the management of the pandemic. Fontana was a nightmare* (Interviewee 2.16, Political Geographer).

Fontana's right had man for health when he took over from Maroni was Giulio Gallera (Lega). Gallera was replaced by Letizia Moratti (FI) in 2021 after massive criticism surrounding Lombardy's response to the pandemic. For more information on the COVID-19 pandemic and Lombardy's role, see Chapter 8.

Conclusion

The Lombard healthcare system chose to go its own way following a quasi-market approach that was supported by the former regional President Formigoni. Under Formigoni's (FI) rule, competition between public and private hospitals was welcomed, GP's were seen as useless, and a regional centrist control over the municipalities was sought. These points did not change drastically when Roberto Maroni (Lega) took over Lombardy in 2013. In fact, he seemed to increase the private healthcare market by subjecting the elderly and the chronically ill to the private market while further disempowering general practitioners. He also continued to centralize the power of the region by threatening mayors who wanted to bring illegal immigrants into their municipalities. Attilio Fontana's legacy will likely revolve around how poorly he and his minister of health managed the COVID-19 pandemic, resulting in the death of countless people in the region. While Maroni might have wanted to follow in the footsteps of Veneto, his reform efforts failed as the system was already institutionalized and there was not much room for successful changes.

All in all, the region of Lombardy is starkly influenced by the early neoliberal Forza Italia management and the quasi-market healthcare system that it implemented. The Lega's role in the region seemed to be more characteristic of the central right Forza Italia with a focus on the privatization of healthcare as opposed to the well-being of regions populous.

Veneto

This section will begin with a political overview of the region, followed by a short description of the Liga Veneta transition into the Lega Nord. Before giving an in-depth view of the region's healthcare system, I look at how Veneto differs from Lombardy. The section will conclude with an analysis of the Lega's impact on healthcare in Veneto.

The Political System

The region of Veneto is located in the Northeastern quadrant of the country. To the East, it is border by Friuli-Venezia Giulia and the Adriatic Sea, and to the West, it borders Trentino-Alto-Adige and Lombardy. Veneto's Southern border is shared with Emilia-Romagna. Unlike Lombardy, Veneto is a semi-presidential representative democracy where the President of the Region is also the regional government's head. Legislative power is held by the Regional Council as well as the local parliament.

Following the 1999 Reform, the election of the President of the Region takes place via universal and direct suffrage. However, contrary to Lombardy, in Veneto, the role of the President not only conforms with art. 121, paragraph 4, of the Constitution (described in the previous section). Rather the President of the Region also has specific duties according to the regional statute. These include, among others, communication and information, implementation of differentiated regional autonomy, federalism, consultative referendums provided for by regional laws, international relations and development cooperation, cross-border and transnational cooperation (Regione del Veneto, n.d.). See Table 21 below for an overview of the Presidents of the Region since 2000.

Table 7.10 Overview of the Presidents of the Region since 2000

President of the Region	**Party**	**Year**
Giancarlo Galan	FI	1995 – 2010
Luca Zaia	LN	2010 – Present

As in Lombardy, Veneto's executive power is found within the Regional Government (*Giunta Regionale*). The regional government functions through resolutions adopted by a majority of its members. These can include bills and administrative acts but have to remain

within the competencies of the Regional Council. The President of the Region can approve regional regulations, except for those delegated by the national government. See Tables 22-25 for some of the most important (for my dissertation) ministries and which party held them.

Table 7.11 Regional Government Galan VII 2000 – 2005

Name	Party	Position
Giancarlo Galan	FI	President: Institutional and Government Policies
Fabio Gava	FI	Vice President: Health Policies
Luca Bellotti	AN	Councilor: Budget Policies (later Marialuisa Coppola)
Antonio De Poli	FI	Councilor: Social Policies
Antonio Padoin		Councilor: Policies for the Territory

Table 7.12 Regional Government Galan VII 2005 – 2010

Name	Party	Position
Giancarlo Galan	FI	President
Marialuisa Coppola	NA	Councilor: Budget policies
Antonio De Poli	FI	Councilor: Social policies
Flavio Tossi	LN	Councilor: Health policies

Table 7.13 Regional Government Zaia IX 2010 – 2015

Name	Party	Position
Luca Zaia	LN	President
Marino Zorzato	PdL	Vice President: Territory, Culture and General Affairs
Roberto Ciambetti	LN	Councilor: Budget and local authorities
Luca Coletto	LN	Councilor: Health
Remo Sernagiotto	FdI	Councilor: Social Services

Table 7.14 Regional Government Zaia X 2015 – 2020

Name	Party	Position
Luca Zaia	LN	President
Gianluca Forcolin	LN	Vice President: Budget and Heritage – General Affairs – Local Authorities
Luca Coletto	LN	Councilor: Health – Social and Health Programming
Manuela Lanzarin	LN	Councilor: Social Services

Source for the above four tables: (Regione del Veneto, 2020b).

As in Lombardy, the legislative power is vested in the Regional Council (*Consiglio Regionale*), also established in 1970. In Veneto, the Council is composed of 51 members. 49 councilors are elected in provincial constituencies via proportional representation, and the remaining two councilors are the elected President and the candidate for President who comes second. To make sure that the elected President has a majority in the Council, the winning coalition wins bonus seats (Rubino, 2015). See Table 26 for an overview of how many seats the majority party had starting in 2000.

Table 7.15 Regional Council Election Results – Majority Party

Election Year	Majority Party and Seats*
2000	FI 17
	LN LV 6
2005	FI 12
	LN LV 7
2010	LN 18
	PdL 13
2015	ZP 13
	LN 10
2020	ZP 18
	LN 13

*Until 2015 the seats were out of 60. Starting in 2015 the seats were out of 51. Also, only the top two parties were chosen from the majority coalition. FI – Forza Italia, LN – Lega Nord, LV – Liga Veneta, PdL – People of Freedom (essentially FI), ZP – Zaia for President.

From Liga Veneta to The Lega Nord

The Liga Veneta (LV) was founded in 1978 by Franco Rocchetta, a Venetian philologist, and is known as “la madre de tutte le leghe” (The mother of all leagues) (Diamanti, 1995). According to scholars, the Liga Veneta (LV), not the Lega Lombarda, was the most important League to develop out of Italy's 1970 ethnoregionalist movements (Maraffi, 1994; Perrino, 2013). The LV had three specific grievances: frustration with the limited powers of the ‘ordinary statute’ for

Veneto (Arban, 2018)[40], a desire to safeguard Veneto's culture and, in particular, its distinct language (Gómez-Reino Cachafeiro, 2017; Perrino, 2013), and a demand for greater fiscal autonomy (Hepburn, 2015). In addition, the Liga was unhappy with the southern-based crime organizations, and they felt that southern Italians were over-represented in public services (Tossutti, 1996).

On January 16, 1980, the LV was officially born. It set out seven objectives, including self-government for Veneto; a reaffirmation of Veneto's culture, language, and history; Veneto's independence from the 'mafia government' in Rome and the maintenance of its taxes and economic resources; the reintegration of emigrants who had been forced to leave Veneto; and support for the European federal project (Riondato, 2005). The party "elected their first senators in the 80s when in Lombardy, the Northern League didn't exist really" (Interviewee 2.21 Economic Sociologist and Social Policy Expert). However, because of only marginal results in the 1984 European Parliament election[41] and the 1985 regional election[42], Rocchetta decided to join forces with the Lega Lombard head Umberto Bossi in 1989. By 1991 the LV joined the LL and other Northern regionalist parties to form the Lega Nord.

It seemed the formation of the Lega Nord was a beneficial solution to all of the leagues in the long run:

> *In an interview released in this period, Bossi declared: `We cannot follow one strategy in Ligury, a different one in Piedmont or in Lombardy or Veneto. Otherwise, we will go back to being marginal autonomous movements. The Venetian, the Lombard, the Piedmontese by themselves cannot get anywhere.*

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[40] It was exceptionally important to the LV to attain the same level of regional autonomy that several special regions, such as Sicily, had been granted post World War II. According to an interview conducted by Cohen in 2007, an early member of the Liga Veneto reported, the party "wanted autonomy similar to what the special regions had, (in order) to keep our money...." (Cohen, 2009).

[41] The LV gained 3.3% in Veneto, but did not win seats (Ministro dell'interno, 1984).

[42] The LV obtained 3.7% and two regional councilors (Jori, 2009).

> *A united north is the only one able to fight the common enemy` [defined in September 1998 as the Meridional Berlusconi, which only a couple of years later became again a political partner when Forza Italia and Lega Nord made an electoral alliance for the 2000 regional elections] (II Corriere della Sera, 24 Sept. 1998)* (Gomez-Reino Cachafeiro, 2000 p102).

Over time, however, especially with the takeover of Salvini as head of the Lega, it appeared that the different leagues had different needs.

What makes the Veneto Case Different?

The case of Veneto differs strikingly from that of Lombardy in several very important ways. These differences are important to understand as they can perhaps explain why the healthcare systems developed differently amongst the two Northern regions with long histories of PRR governments.

The first difference has to do with political geography and history. Both Lombardy and Veneto were

> *considered to be very relevant for the Italian economy. While in Lombardy you have basically big enterprises, multinational companies, the financial center of Milan and so on. In Veneto you have basically smaller companies, family driven companies, the famous industrial driven model, you know, it was developed exactly in Northeastern Italy, in Veneto* (Interviewee 2.16 Political Geographer).

Sometimes referred to as the "Veneto development model" or the "industrial district model," the Venetian industry is made up of local clusters known as *distretti* (The Business Year, 2020). These small, private enterprises (Tossutti, 1996) prided themselves in producing items that the surrounding provinces are known for, for example, agro-food in Verona, textiles in Treviso and Vicenza and glass in Venice (European Commission, n.d.). This model

> *became very famous in the 70s because it was able to resist the petroleum crisis shocks. So, when the price of petroleum increases it negatively impacted the big companies. You know, if you have a big company, big integrated, with thousands of employees, you are not flexible. So, if you have a raw material*

> *where the price increase, you have problems for the entire industry. While, on the other hand, if you have a model like in Veneto made up of medium and small enterprises we are talking about really small enterprises in some cases, which work together then you are much more flexible to react. So in the 70s this model became very famous and we had thousands of studies of this industrial district model (Belussi et al., 2012; Deiottati, 2009; Staber and Sharma, 1994). And before the spread of globalization, we really had people coming to Veneto to study this model and so on. What happened with globalization, is that this model, these territories of Northeastern Italy suffered more than Lombardy. Exactly because of the fact that they also produced a lot in sectors that were impacted by globalization and Chinese competition and whatever* (Interviewee 2.16 Political Geographer).

Lombardy did not need the Lega's help to combat globalization because they already had their big multi-national industries. With more than 800,000 companies in Lombardy, the region has one of the highest rates of entrepreneurship in Europe (European Commission, n.d.). The Liga Veneta, however, appealed to the small private enterprises in Veneto who not only feared economic decline but also resented the fact that their taxes were being sent to the South (Tossutti, 1996).

This industrial distinction leads nicely into the second difference, namely how the two regions were seen. The north-west, most prominently, Piedmont and Lombardy, were part of the traditional Fordist model[43], while Veneto was characterized by "diffuse industrialization, regional networks, and local economies" (Gomez-Reino Cachafeiro, 2000, p 86). Thus, while Lombardy could be seen as core regions in economic and political terms (Gourevitch, 1979), Veneto was seen more in terms of territorial identity and therefore had a strong inclination to develop a very ethnically based party. Regarding their politics and political action, the Lega Lombarda was labeled as having a more "populist" nature. At the same time, the Liga Veneta was described as having a more "ethnic" nature (Roberto, 1997). The populist appeal of the LL

[43] A manufacturing system designed to produce low cost standard goods that workers could afford (Torricelli, 2014).

is likely what made it more successful than any of the other Northern Leagues making a unified League politically more appealing.

Culture and language mark the third difference between the two regions:

> *Veneto has an autonomous, neutral and independent tradition. I mean, it's not like Catalonia, of course, but also, it's one of the Italian regions in which they actively speak their regional dialect. They commonly speak Venetian and they've got this autonomous tradition* (Interviewee 2.21 Economic Sociologist and Social Policy Expert).

According to Sabina Perrino's qualitative interviews, the Lega Nord in Veneto attempted to revitalize the Venetian dialect to set itself apart from other regions (Perrino, 2013). So, while the Lega Nord was created as a regionalist party united not by language, rather by territory, the Liga Veneta added the linguist element to its cause. While Lombardy and Piedmont also claimed protection and recognition of their regional languages in the Italian institutional framework (Gómez-Reino Cachafeiro, 2017), they weren't as insistent as Veneto. In their 1982 manifesto, the Liga Veneta stated: "We are neither Celts nor Salvs, neither Italians nor Germans, but Venetians, and it is our firm intention to continue to be so" (Gómez-Reino Cachafeiro, 2017, p 75).

These differences (industrial, economic, and cultural) culminated when Salvini took over the Lega and turned the regionalist LN into the national Lega:

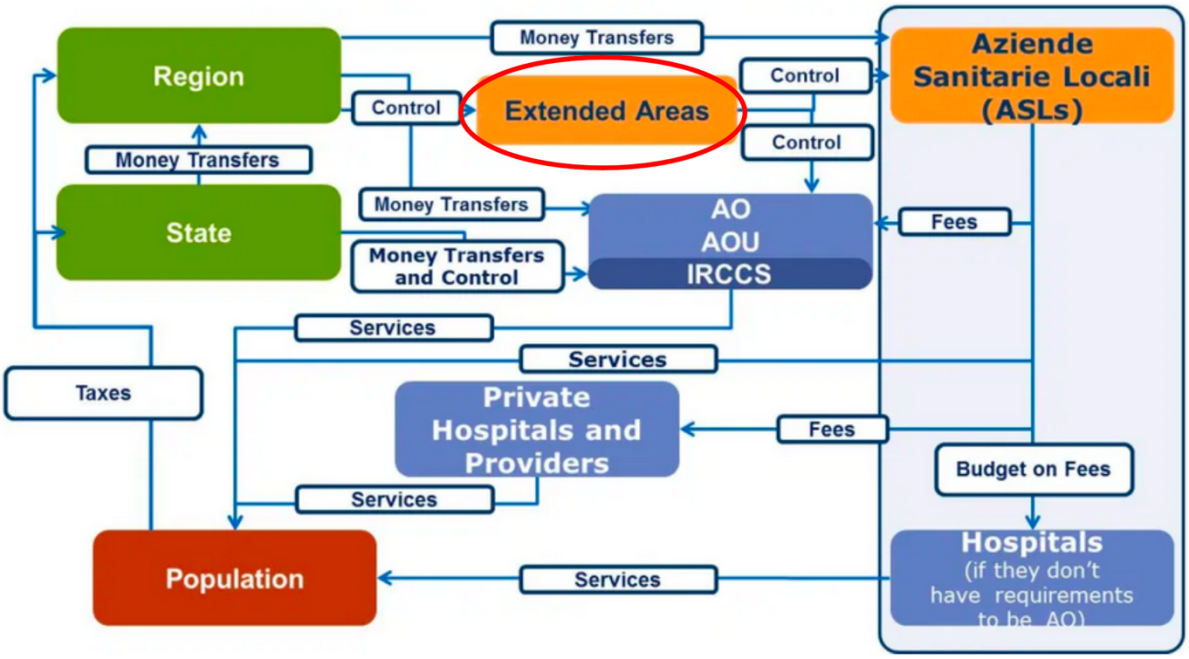
> *Salvini scaled up and this was successful, but then you have the Lega which is still a local party particularly in Veneto, but also Friuli Venezia Giulia. You have these very strong local Lega parties, which to some extent they are connected with the central Lega. This scaling up that Salvini did, as far as I know, was not accepted by all of the Lega. There is still a part of the Lega that wants to keep it about the Northern Regions* (Interviewee 2.16 Political Geographer).

Over time it seemed that the values of the regional leagues drifted apart. While the LV still belongs to the Lega party, it has its own agenda and focus, somewhat different from Lombardy's.

Healthcare system

As previously mentioned at the beginning of this chapter, Veneto follows the Aree Vaste model of healthcare. The only difference between this model (depicted below in Figure 17) and the classic Italian healthcare model is that there is an extra level of bureaucracy between the regional government and the local health units (ASL).

Figure 17 Veneto Healthcare Model



Source: (Biselli, 2016).

Similar to all the other regions, the regional government is responsible for the health system through the departments for health and social services. There are four levels of care within the Venetian system: acute care, intermediate care, residential care, and domiciliary care. According to (WHO, 2016) there are 17,000 beds organized within a far-reaching network of two regional centers (AO's), five provincial hospitals, a cancer center, 17 general district hospitals, and three private hospital centers. Intermediate care refers to the rehab centers, hospices, and community

hospitals, while residential describes the care provided in standard old age homes. Domiciliary care covers around 120,000 people who suffer from some sort of chronic problems best treated at home.

Everything that is managed outside a hospital, such as primary care, mental health, or palliative care, is done so at the district level. For example, primary care is organized in such a way that the patient is provided with an integrated medical team that offers 24-hour support and provides a link between primary care and hospital services. This interconnectedness of medical services is what makes the Venetian system unique.

Unlike the Lombard system, the Venetian health care model is characterized by "a strong orientation towards meeting the needs of individuals as well as the community through the integration of health and social services" (WHO, 2016, p 16). This becomes apparent when one looks at where the power to make healthcare decisions is in each region.

> *In Veneto I, I think regional bureaucracy is still very strong. And that will be, this was one of the elements which explains the most to the success of Zaia in managing the pandemic. But I mean, regional power is strong, but the power is probably more distributed, between the regional bureaucracy and local managers. in Lombardy they share the opinion that municipalities. In Lombardy, on the other hand, local mayors have no influence on healthcare. While certainly in Veneto, they have some to a certain extent, to a certain extent they have some influence* (Interviewee 2.21 Economic Sociologist and Social Policy Expert).

While the decision-making power in Lombardy is strictly regionally based, with regards to healthcare, in Veneto, decisions are more devolved, fitting nicely with the community-based model and the integration of services. Also, contrary to the Lombard model, primary care plays a central role in the Venetian system. Thus, it is not surprising that the GP is the first contact point for patients (Ghiotto et al., 2018) and central to the Venetian healthcare system.

Interestingly, the Lega does not have a provincial majority (See Table 27 below), in fact, there are more independent and center-left parties that placed their mayors in the last years. Perhaps the cooperation, in terms of health, is better with center-left parties in Veneto, which is why the Lega has not tried to consolidate power regionally.

Table 7.16 Veneto: Provinces, Mayors, and the Parties they are associated with.

Province	Mayor (since)	Party
Treviso	Mario Conte (2018)	Lega
Verona	Federico Sboarina (2017)	Forza Italia (FI)
Padua	Sergio Giordani (2017)	Democratic Party (PD)
Vicenza	Francesco Rucco (2018)	Independent
Venice	Luigi Brugnaro (2015)	Independent (center right)
Belluno	Jacopo Massaro (2012)	Independent (center left)
Rovigo	Edoardo Gaffeo (2019)	Independent (center left)

In any case, it is interesting to note that when it came time to decide what healthcare model to follow, the Presidents of the Regions in both Lombardy and Veneto (Formigoni and Galan, respectively) were from the Forza Italia party, and yet, they chose different models.

The Lega and Health

As was depicted in the previous section:

> *Veneto had a traditionally more public-based healthcare provision, at least in hospitals. So, for a long time, the right governments, the Forza Italia governments first and the League afterwards, were not so keen in expanding private markets* (Interviewee 2.21 Economic Sociologist and Social Policy Expert).

Both Lombardy and Veneto had regional presidents belonging to the Forza Italia (FI) party when it was decided that healthcare would devolve to the regions. Thus, as in the case of Lombardy, it is important to begin this analysis before the Lega came to presidential power in Veneto.

Giancarlo Galan (1995 – 2010)

Unlike Formigoni in Lombardy, Galan did not come from the Catholic faction of Forza Italia, "he did not come from this specific movement called the Comunione e Liberazione" (Interviewee 2.21 Economic Sociologist and Social Policy Expert). Thus, when it came time to decide what kind of healthcare system the region should implement, he opted

> *for a more traditional system, placing much more importance on outpatient care and public services. So, in some ways Veneto, the organization of the health care system is more similar to Emilia-Romagna and Tuscany, so the red, social democratic, regions* (Interviewee 2.21 Economic Sociologist and Social Policy Expert).

Following this line of thinking:

> *In Veneto, healthcare stems out of the embeddedness... So there's a different idea. In this sense, the Northern League in Veneto has practically followed the Christian Democratic Party when it was formed there, which means institutions are fine, but they are rooted in local societies, Catholic local societies. So there must be a lot of embeddedness on how institutions including hospitals and healthcare work. So it's more a communitarian idea. There is no markets, no market ideas involved.* (Interviewee 2.17 Economic Sociologist and Social Policy Expert).

According to some scholars, Catholicism influenced the Venetian branch of the Northern League (Bull and Gilbert, 2001), thereby imbedding the subsidiarity principle into their understanding of health and social care, also one of the main principles embraced by social Catholicism (Vampa, 2016b). Naturally, this implies that more emphasis was placed on the social role of sub-regional actors, such as municipalities and local cities. This concept allowed the Venetian welfare model to develop into a 'polycentric' system (Ciarini, 2012), a form of governance in which various governing bodies interact to make and enforce decisions (Carlisle and Gruby, 2019). The previously discussed notions, so important to the Venetian core, of regional autonomy and the strengthening of a regional identity, likely contributed to this polycentric and local-based, rather than region-centric (Vampa, 2016b) social system.

So, while in Lombardy, the Catholic movements, specifically the Comunione e Liberazione[44], drove Lombard President Formigoni (FI) to support a quasi-market system, there was no Catholic influence on Veneto President Gallan (FI). The catholic movements might have influenced the LV, but by the time Luca Zaia (Lega) became President of Veneto in 2010, the Venetian healthcare system had already been implemented. "Ideologically speaking, in my opinion, the Lega, in general, is more pragmatic, and much less market-oriented" (Interviewee 2.21 Economic Sociologist and Social Policy Expert), which might explain why Zaia did not attempt to change the Venetian healthcare system. While Maroni (Lega) in Lombardy did (he wanted to make it less market-oriented, more communal, and more social), and failed.

Luca Zaia (2010 – Present)

As previously mentioned, the Venetian healthcare system was already very community-oriented when Zaia took over as President of the region in 2010. Both Zaia and his regional Council, led by Health Minister Luca Coletto, supported Galan's system. They "followed this traditional path" (Interviewee 2.21 Economic Sociologist and Social Policy Expert), making no efforts to change it into something more market-oriented. In fact,

> *I don't expect privatization, I expect that they kept on investing in public healthcare; in Veneto at least. my impression in Veneto was the League was just keen in organizing the system, not in transforming it* (Interviewee 2.17 Economic Sociologist and Social Policy Expert).

[44] "This was a movement born in the early 70s. It was a sort of reaction against the mobilization of the left parties and left movements in the 70s. It's a group, you can think of as the Catholic right. A group that wanted to essentially merge Catholicism and neoliberalism – less state more market was their slogan in the 80s" (Interviewee 2.21 Economic Sociologist and Social Policy Expert).

In 2012, the Zaia government implemented a regional planning legislation (LR 23/2012) that made the system even more patient-oriented by placing the person at the healthcare system's center (Ghiotto et al., 2018). Four years later, in 2016, the government passed the Regional Law (LR 19/2016) defining a new primary care model in which Integrated Medical Groups were promoted. In fact, the law suggested that by the end of 2017, 60% of all the GP's in the region should be part of such a group (The Regional Council, 2016). With this change, the idea that "Veneto is a lot closer to Central Italy" regarding healthcare was confirmed. Unlike in Lombardy, where GP's were seen as useless, Veneto praised GP's as being "an important part of the network, of the care network" (Interviewee 2.17 Economic Sociologist and Social Policy Expert). These changes solidified the patient and community-oriented nature of the Venetian system. As we will see in the next chapter, these changes will set Veneto apart from Lombardy with regards to the first wave of the corona pandemic.

Conclusion

As can be deduced from this section, Veneto has an entirely different approach to healthcare than Lombardy. Even with a President from the Forza Italia party, the region chose a more "social" or "traditional" healthcare model. This model resembled those of Emilia Romagna and Tuscany (both Social Democratic strongholds) much more closely than Lombardy. Despite the similar political trajectory, reasons for this difference can be found in the cultural history of the region.

Uninfluenced by the catholic movement Comunione e Liberazione, President Galan, created a healthcare system that provided a mix of hospital and community care that regarded the GP as an essential entity. When President Zaia replaced Galan, he continued to support this well-balanced system and took it a step further, making it even more patient-focused and placing the

GP in an even more central light. Instead of changing the system, like his colleagues in Lombardy, Zaia expanded on what his predecessor implemented, making the system even more efficient.

While the Catholic religion also influenced the Veneto region, its small business and community-oriented mentality steered it to create a healthcare network that not only served the region well before the pandemic but proved useful during the pandemic.

Conclusion: Lombardy and Veneto

This chapter presented the cases of Lombardy and Veneto, two Italian regions with similar political trajectories. Both regions were in the hands of the center-right Forza Italia (FI), beginning in 1995 until at least 2010 when Lega Presidents took over. Despite having the same parties in power, their healthcare system developed much differently and with very contrary foci.

In Lombardy, President Formigoni (FI) created a healthcare system unique to Italy. He followed a quasi-market model wherein patients could choose whether they wanted to use public or private hospital facilities. The system he created revolved around the hospital as the center for care, thereby deeming a general practitioner (GP) useless. The result was an unbalanced system as only hospital care was given support. Formigoni's successor, Roberto Maroni (Lega), realized this and attempted to balance out the system. After several failed attempts to move care outside of the hospital to accommodate the growing elderly and chronically ill population, his term ended. An even less successful Attilio Fontana (Lega) took over as President of the region in 2018. A weak presidential presence coupled with ineffective advisors and an ill-equipt system led Lombardy to become the poster child of pandemic failures during the 1st wave of the COVID-19 outbreak.

The role of the PRR Lega in health was minimal in the region. Lega Health Minister's C'è and Bresciani (under Formigoni) both stepped down due to conflicts with the President leaving them powerless in their roles. When Maroni took over the Presidency, change was attempted but ultimately failed due to the ingrained network of Forza Italia and Catholic Comunione e Liberazione officials making any substantial changes near impossible. During the Maroni period, it could be speculated that the Lega leader wanted to change the Lombard system to resemble that of his Venetian colleagues; however concrete evidence remains uncovered. Under the leadership of Fontana, the COVID-19 pandemic laid bare the systems shortcomings as well as the initial leadership issues surrounding the President.

In Veneto, Giancarlo Galan (FI), uninfluenced by the ultra-conservative catholic movement (Comunione e Liberazione), created a more integrated healthcare system. Four levels of care created a more balanced system wherein the GP was given the traditional role as gatekeeper and seen as an essential part of the system. The historically more communal and interconnected region made it necessary to create a connected and more community-oriented healthcare system. When Luca Zaia (Lega) replaced Galan in 2010, he expanded this system, making it even more patient-centered and more organized. Unlike his colleagues in Lombardy, he did not see the need to change the existing system as it presumably worked well. This efficiency was supported during the pandemic's 1st wave when despite being a very impacted region, case numbers and deaths tolls were marginal compared to those of Lombardy.

What can be seen from both of these cases is that the impact and influence of the Lega was very path-dependent. In Lombardy, the healthcare decisions made by FI and the influence FI still has surrounding the healthcare system in the region made it difficult for the Lega to make changes despite having the Presidency as well as control over the Health Ministry. Although

Lega President Maroni recognized the system was sub-optimal for a rapidly aging population, he was virtually powerless to change anything, despite multiple attempts. In Veneto, the health decisions made by FI were well-balanced and ultimately proved successful. Thus, they were adopted and expanded by Zaia.

The different trajectories and paths taken by the regions and the power of the respective PRR successors were very embedded in both regions' history and culture. Thus, these cases are perhaps less a display of PRR health competencies and more a lesson in culture, tradition, and influence.

Chapter 8 **: COVID-19 in Austria and Italy**

I began my research on the impact of populist radical right (PRR) parties on health before the outbreak of COVID-19. With the onset of the pandemic, I was able to add to my research shedding new light or confirming previous findings. My research was designed to create leverage because the literature on the intersection of health and political science, particularly how the populist radical right impacts health, is thin at best. I maximized the number of cases available since not many countries have populist radical right parties in government by including the subnational level. This allowed me to increase the number of cases under investigation.

COVID-19 turned out to be a big test for both healthcare and health policies. In Italy, we saw regions governed by the PRR and regions not governed by the PRR garnering diverse results. In Austria, we saw a deflated PRR party in opposition both nationally and subnationally. Their reactions were predictable and had little to do with actual health policy solutions.

In this chapter, I will begin by giving a quick overview of the corona situation in both countries from the beginning of the pandemic until January 2021. Then, I will focus on the COVID-19 reactions on a national level for Austria and Italy, even though the PRR in both countries is "only" in opposition. Subnationally, I will only look at Italy because there are no PRR parties in government in Austria. I will use the cases of Lombardy and Veneto to highlight how two regions, both governed by the same party (Lega), had different outcomes, at least

initially. The indicators I will use to show this are the number of cases, the number of tests administered, and ICU capacity.

COVID-19 and the PRR in Opposition

Austria

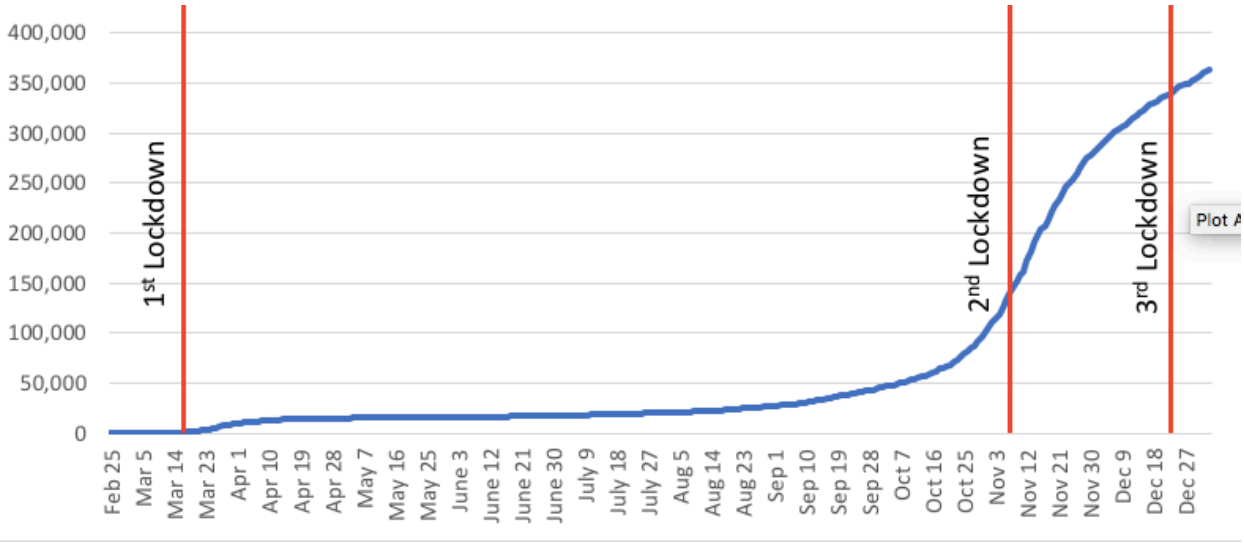
After the September 2019 election in Austria, the new ÖVP formed a new coalition government with the Austrian Green Party wherein Rudolf Anschober (Green party) assumed the role of Health Minister. This implies that the FPÖ was not in government and thus established itself as an effective oppositional force. When the coronavirus broke out in early 2020, the FPÖ supported the national government's course stating mid-March that the "direction of the government in the last few days was correct." However, FPÖ club chairman Herbert Kickl added that "many sensible measures were started much too late as valuable time was lost with the government concentrating on crisis PR instead of focusing on crisis management" (Freiheitlicher Parlamentsklub, 2020b).

The first confirmed COVID-19 case in Austria was on February 25th. The FPÖ was the first party to demand a comprehensive lockdown during a press release on March 13th (Freiheitlicher Parliamentsklub, 2020); the government passed this three days later on the 16th (see Figure 18). This occurred just one day after the national council agreed to the COVID-19 laws. The first hard lockdown saw the closure of all shops except those that sold basic supplies (grocery stores, pharmacies, and drug stores), as well as all cultural institutions, and even the federal gardens and swimming pools had to remain closed. Most air traffic was discontinued, and

strict contact and exit restrictions based on the COVID-19 law came into force. Restaurants, cafes, bars, and restaurants were closed on the following day.

By the end of March, Kickl demanded that asylum seekers in Austria not only be quarantined but also that their right to asylum should be suspended: “We will need all of our resources for our own population in the coming months. Period. Everything else is a slap in the face to the Austrians, who are already being asked a lot by the rigid measures against the coronavirus” (Freiheitlicher Parlamentsklub - FPÖ, 2020).

Figure 18 Number of daily confirmed coronavirus (COVID-19) cases in Austria since February 2020



Source: (WHO, 2021).

On April 15th, Austria took first steps towards reopening and chose a staggered exit strategy. The country began by opening small stores and continued with the opening of other businesses and schools in 2-week intervals until the eventual opening of hotels and museums by the end of May (Desson et al., 2020). By the end of April, the FPÖ began heavily criticizing the national government calling for normalization and even going so far as to launch a campaign for a petition called “Jetzt reicht’s! - Allianz gegen den Corona-Wahnsinn” [it’s enough! – alliance

against the corona madness]. In their campaign, they demanded that the government take back all measures that reduce personal freedoms (Falkenbach and Greer, 2020), especially those related to the freedom of movement (including travel) and anything pertaining to economic restrictions (i.e., store and restaurant closures). They also called for a quick opening of educational institutions and a withdrawal of any general restrictions to public events. Despite existing evidence of the effectiveness of face-masks, the campaign claimed: "Too many citizens suffer from the entirely useless coercion to wear face masks…even though face masks evidently provide no protection" (Freiheitliche Partei Österreichs, 2020).

By the end of October, amid the second wave of the pandemic, Kickl called for a change in strategy, arguing that instead of curfews, asymptomatic people should no longer be tested. The FPÖ, as well as the other opposition parties (SPÖ and NEOS), were asking why all of the necessary preparatory measures such as expanding hospital capacities and implementing better measuring and counting instruments were made during the summer months (Kurier, 2020). The critic of all opposition parties, but particularly that of the FPÖ, intensified when the government announced a second complete lockdown, including school closures to go in effect on November 17th at midnight. Not only did the FPÖ accuse the government of creating a "lost generation" through continued school closures (Austrian Press Agency, 2020c), but also stated that this new lockdown "would carry Austria to the grave" (ORF, 2020c). The country ended the second lockdown a few weeks before Christmas only to announce a third lockdown for December 26th.

Even before a COVID-19 vaccine was approved, the FPÖ already mobilized against vaccination. On September 9th, for example, the FPÖTV released a spot on YouTube, reinforcing their viewpoint that compulsory corona vaccinations are wrong and that they are doomed to fail (FPÖ TV, 2020). In addition, the FPÖ published a press release in which they

clearly positioned themselves against mandatory vaccinations (Freiheitlicher Parlamentsklub, 2020a). Norbert Hofer, head of the FPÖ, announced that he would not get vaccinated, trusting instead his "good immune system" (ORF, 2020).

At the time of writing (January 2021), the Austrian government was confronted with the decision of whether to extend the hard lockdown from December (which was set to end on January 24th) or not. Proposals such as "*Freitesten*[45]" or "testing yourself free" have been struck down as unconstitutional by the three opposition parties. The FPÖ sees no reasons for lockdowns anymore, and Kickl announced that "lockdowns are pointless from a health politics standpoint and because they are unconstitutional" (ORF, 2021).

Italy

With over 2,220,300 confirmed cases and more than 77,291 deaths (New York Times, 2021) at the time of writing, Italy was the first country on the European continent crippled by the coronavirus. Although a state of emergency was declared at the end of January 2020, just a few days after the first case was discovered, country leaders, as well as medical professionals, underestimated the outbreak. Authoritarian public health measures were not promptly implemented; instead, regions were initially left to deal with the virus as they saw fit, thereby creating a fragmented containment approach (Falkenbach and Caiani, 2021). There was no immediate country lockdown; this came about two weeks after the third confirmed death (Hirsch, 2020). Alternatively, the country took a gradual approach quarantining hard-hit municipalities first, then locking down certain northern regions and culminating in a complete country

[45] This would have granted people that participated in the mass corona tests set for January 17th access to restaurants, stores and hotels one week before the hard lockdown measures were set to be lifted.

lockdown by March 9th, 2020. Precious time was wasted with miscommunication and a general miscalculation of the disease's severity, ultimately resulting in a strict and lengthy countrywide lockdown that led to drastic socioeconomic effects (Falkenbach and Caiani, 2021).

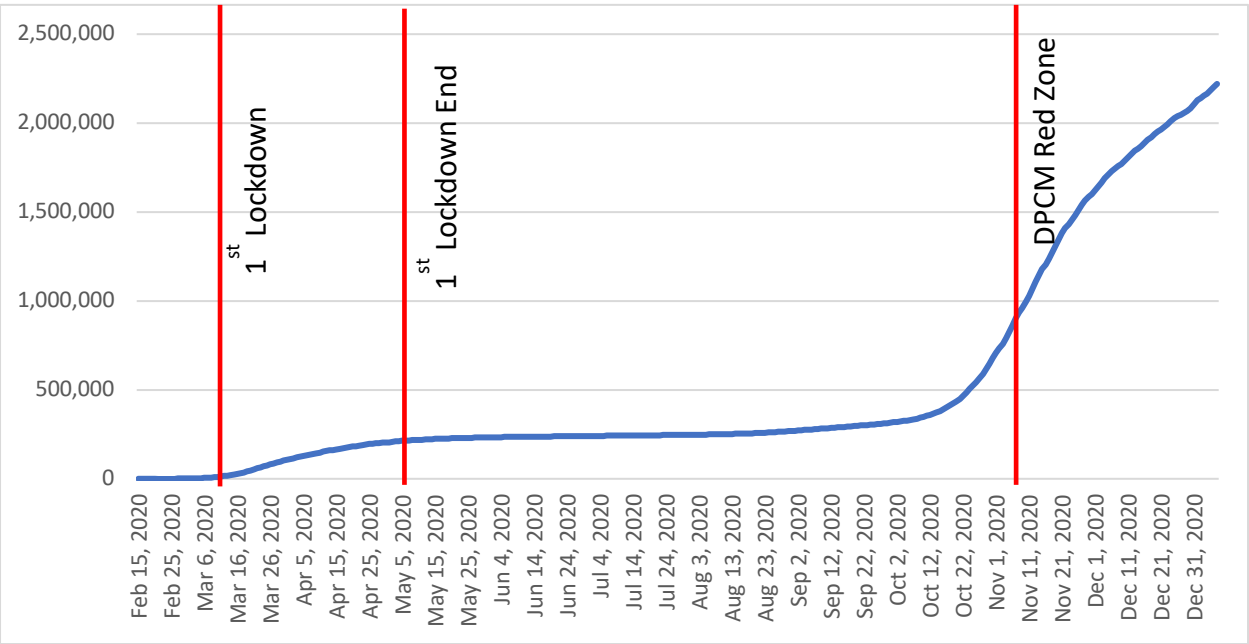
Although the citizens' trust in Prime Minister Conte was high, there was apparent disagreement among the parties, resulting in the pandemic's politicization (Capano, 2020). Populist radical right (PRR) parties such as the Brothers of Italy led by Giorgia Meloni or Matteo Salvini's Lega regularly criticized the government for its weak leadership and the European Union (EU) for its lack of solidarity.

Both Salvini and Meloni initially negated the evidence of the pandemic. Salvini's Facebook posts encouraged followers to continue with their everyday lives, while Meloni told her Facebook followers not to believe anything said on TV (Nardelli and D'Urso, 2020). By March, when it seemed the virus was spiraling out of control in Italy, Salvini stayed quite content to let the government make the difficult decisions. However, at the end of the month, when he noticed increased frustrations due to the lockdown, Salvini found his voice again and started firing critique towards the Italian government and the EU. In April, he staged a two-day occupation of the Italian parliament to protest the lockdown demanding the restoration of full liberties (Roberts, 2020).

After the 1st lockdown (see Figure 19), shortly before the summer of 2020, both Salvini and Meloni adapted their rhetoric to the normalization and consequent awareness of the emergency, wherein Salvini argued that the lockdowns were not going far enough and that everything needed to be shut down. Both PRR leaders started attacking the EU's response to the crisis, and they released a video stating that the virus was bioengineered in China (Nardelli and

D'Urso, 2020). The PRR flank blamed the government for not being able to make substantive decisions and implementing them.

Figure 19 Cumulative number of coronavirus (COVID-19) cases in Italy since February 2020



Source (Il Sole 24 Ore, 2021).

Not only did the Italian PRR blame the government for anything that went wrong during the pandemic, but they also capitalized on the crisis, scapegoating on their traditional targets (i.e., immigrants and minorities) (Falkenbach and Caiani, 2021). When a boat carrying several hundred migrants from Africa was granted access to the Sicilian harbor in late February, Salvini accused Prime Minister Conte of being unable to shield Italians from a disease outbreak in Italy (Thrilling, 2020). Salvini claimed that by allowing migrants from Africa to land in Italy, Conte was being thoughtless (Smith, 2020). Salvini used this humanitarian act to further his agenda against immigration in the middle of the pandemic advocating to tighten security along the

Italian border (Nugent, 2020). Aside from the latent impact previous Lega policies had during the pandemic, Salvini greatly influenced the discourse surrounding the coronavirus as a member of the opposition. Initially, he used the pandemic to continue his anti-immigrant rhetoric, going so far as to blame them for bringing the virus to Italy. Then, he was silent, only to emerge again with attacks on the scientific community (regarding masks) advocating for a quick return to normality.

The coronavirus pandemic coupled with the increased support for the PRR shed new light on the problems associated with managing refugees and migrants in the country. Refugees, asylum seekers, and migrants were among the most severely impacted by the crisis (Caritas, 2020). Thanks to the "Salvini decree", discussed in Chapter 6, additional stress with the corona pandemic outbreak was caused because both healthcare and support for housing are two pressing needs for migrants, particularly during a pandemic (Marchetti et al., 2020). If an undocumented migrant was not a resident of Italy, then they were unable to register for the Italian National Health Service, thereby impeding their access to services (Carlotti, 2020). No measures were adopted under the new Conte government to ease the access for undocumented migrants to attain services or provide other useful measures to protect the migrant communities from the virus (Falkenbach and Caiani, 2021).

While Matteo Salvini's favorability decreased during the pandemic's 1st wave, Luca Zaia, the governor of Veneto and more moderate Figure within the Lega party, experienced a political boost. Zaia's handling of Veneto's crisis, one of the regions most affected by the pandemic, garnered him much support. Not only did this lead to his third term as governor (Pianigiani, 2020), but it also made him the second most loved politician in Italy (51 percent of the

consensus) behind Prime Minister Conte (Roberts, 2020). This fact nicely leads into the second section of this chapter, namely the subnational cases of Veneto and Lombardy.

COVID-19 Subnationally

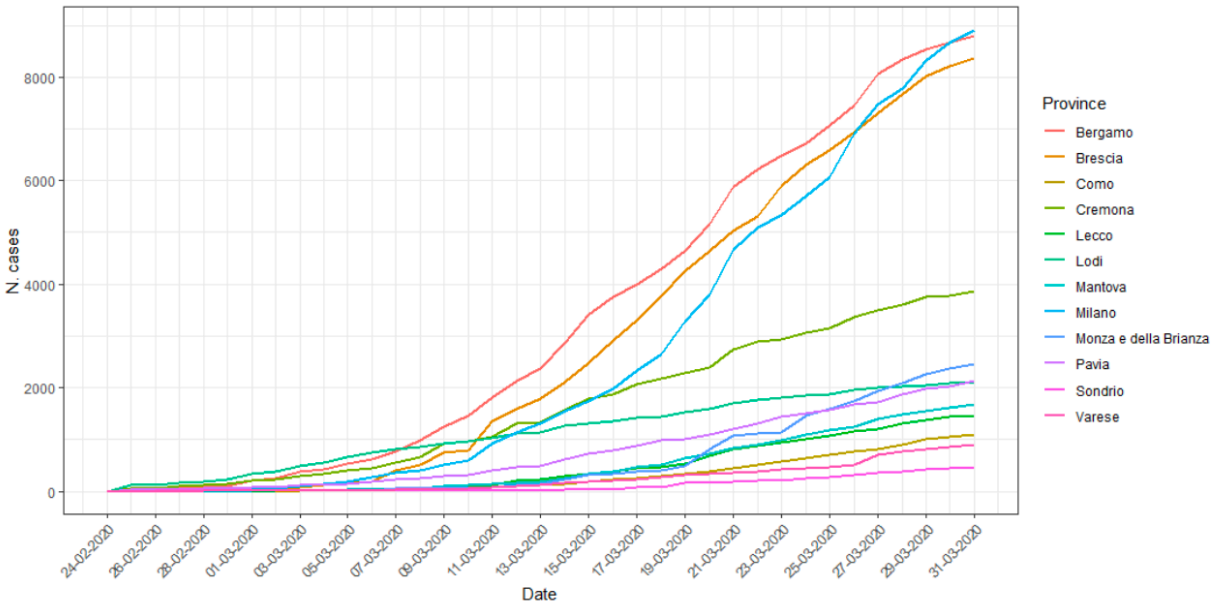
As is clear from the previous chapter (Chapter 7), during the COVID-19 outbreak in 2020 and at present (2021), the Veneto region is governed by Luca Zaia (Lega) and the region of Lombardy is governed by Attilio Fontana (Lega). There were two initial epicenters of the pandemic outbreak; one was in Codogno, in the province of Lodi in Lombardy, and one in Vo', in the province of Padua in Veneto. I will use the rest of this chapter to look at how these two regions dealt with the pandemic's onset. As mentioned in Chapter 6, healthcare administration is a competency belonging to the regions; therefore, the regions are responsible for acquiring, storing, and administering COVID-19 tests. Thus, it comes as no surprise that the regions, particularly Lombardy and Veneto, the hardest hit, chose different strategies.

Lockdowns

The earliest and most significant lockdowns were created in the form of "Zona Rossa's" or red zones in the two areas where the virus first broke out. On Sunday, February 23rd, 2020, the Minister of Health, Roberto Speranza (Article One – SD), and the President of the Lombardy Region, Attilio Fontana (L), signed an order that would impact the region of Lombardy. In particular, the order created, so-called "red zones" for the municipalities of Codogno, Castiglione D'Adda, Casalpusterlengo, Fombio, Maleo, Somaglia, Bertonico, Terranova dei Passerini, Castelgerundo, and San Fiorano, all located within the province of Lodi (See Figure 20 below showcasing the high infection numbers in Lodi compared with the other municipalities in

Lombardy in February). In these municipalities, all schools would be closed, all events would be suspended, all cultural institutions would close, and people living in these areas would not be allowed to leave (Fontana and Speranza, 2020).

Figure 20 The trend of infection in the provinces of Lombardy from February 2020 to March 2020

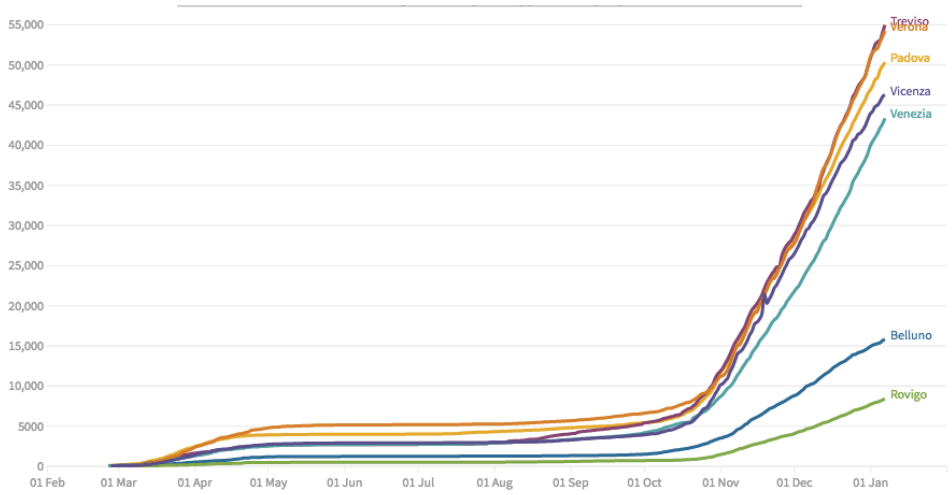


Source: (Bertazzoni et al., 2020).

A similar order was signed between Speranza and the President of Veneto, Luca Zaia (L), creating a red zone for the municipality Vo' Euganeo close to the city of Padua (see Figure 21 below for infections per municipality in Veneto). This occurred because the local mayor immediately agreed with the president of the region (Zaia) and the national government (Speranza and Conte) to close the town and impose a strict curfew (Romagnani et al., 2020). The ordinance signed would provide Zaia with measures to contain the virus via the measures listed above. The ordinance also listed several precautionary measures people should follow, such as

washing hands, avoiding close contact with people, etc. (Zaia and Speranza, 2020). “I have been saying and repeating it for weeks: the virus has no political colors. We are at war, in Veneto as well as in Rome. And at the moment there is no other remedy than to isolate the outbreaks” (de Luca, 2020). Measures such as, for example, closing schools and universities, suspending even the Venice Carnival, blocking aggregation centers, sporting events, even religious ceremonies would be implemented (Zaia and Speranza, 2020). In addition, Zaia stated at the beginning of March 2020 that he remained convinced that a standardized approach “from north to south” should be sought after, “given that the virus knows no boundaries” (Italia Oggi, 2020).

Figure 21 The Trend of Infections in the Provinces of Veneto from February 2020 to January 2021



Source: (Gedi Visual, 2021).

While both regional presidents (Fontana and Zaia) created red zones in their regions, Fontana failed to convey the disease's severity to the critically hit province of Bergamo. Between February 27th and 28th, the Confindustria Bergamo (Bergamo’s Confederation of Business Industries) posted a video meant to reassure the international business community that ‘Bergamo is running’ as usual (Confindustria Bergamo, 2020). Even the mayor of Bergamo, Giorgio Gori

(Democratic Party), initially supported this mentality (Il Giorno, 2020). These attitudes led to a delayed lockdown in Bergamo and the neighboring towns of Nembro and Alzano, costing many lives. Not until March 3rd did the scientific committee of the Italian Higher Health Institute (ISS) advise to implement red zones for Alanzo and Nembro (Imarisio et al., 2020). On March 8th, the national government turned the region of Lombardy into an "orange zone". No "red zone" or additional restrictions were applied to Alzano, Nembro, or Bergamo, meaning that most business activities and manufacturing companies could continue working – these are finally closed on March 23rd (Galizzi and Ghislandi, 2020a).

After the damage was done (see Table 28 showcasing the number of cases and deaths as of April 15th compared with Veneto and the country as a whole), Bergamo became one of the hardest-hit provinces worldwide with 5,138 deaths in March alone (Buonanno et al., 2020a). Rome claimed that the regional government would have needed to implement the lockdown, while the regional government blamed Rome and said that local mayors should have intervened more forcefully (Galizzi and Ghislandi, 2020b). The local mayors, in turn, accused the regional government of concealing data to avoid the lockdown.

Table 8.1 COVID-19 surveillance data in the Lombardy and Veneto regions versus the rest of Italy as of April 15th, 2020

	Cases	**Deaths**	**Case Fatality Rate**
Lombardy	62,153	11,377	18.3%
Veneto	14,624	940	6.4%
The Rest of Italy	88,378	9,328	10.6%

Source: (Odone et al., 2020).

There were two main reasons as to why reactions were so different within the two regions. The first has to do with coordination. There was "a huge coordination problem between the regions and the central government. There was a lot of confusion as to who actually had the power to impose red zones and judges will be investigating this" (Interviewee 2.17 Economic Sociology and Social Policy Expert). Zaia in Veneto didn't wait for approval from the central government to impose red zones; instead, he coordinated with the local municipalities, which the central government approved. Fontana in Lombardy took a different path. He created the red zones in the province of Lodi with the approval of the central government but failed to extend these red zones to the nearby municipalities of Bergamo and Brescia. One reason for this supposed oversight is that there "are no manufacturing sites in Lodi. Whereas Bergamo and Brescia are at the heart of Lombardy production" (Interviewee 2.17 Economic Sociology and Social Policy Expert). So, there was a lot of resistance coming from municipal mayors, and Fontana simply did not have the political clout to stand up to them. After the death counts surged and citizens became upset, local governors, as well as Fontana and the national government, blamed each other. According to an economic sociologist and social policy expert, they said: "We did not introduce red zones because the national government did not tell us to do it" or "we asked the regions to introduce red zones, but they said they were not necessary" (Interviewee 2.17 Economic Sociologist and Social Policy Expert).

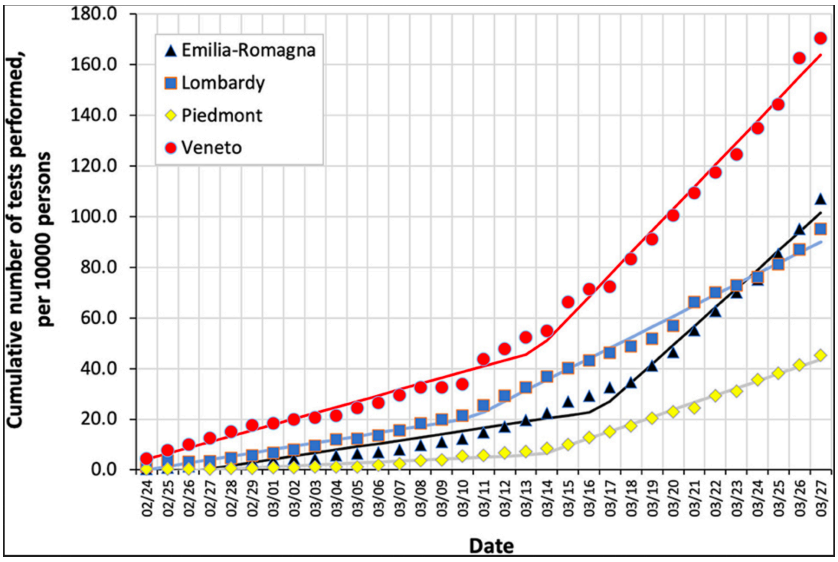
The second problem surrounded the underestimation of the "true" case numbers in Lombardy. Lombardy simply was not testing enough as they followed the national government's advice to only test patients with clinical symptoms and those that had been in contact with an infected patient. This can also be seen as a primary reason for the slow and uncoordinated

reaction regarding lockdowns in the province of Bergamo (Buonanno et al., 2020b). This fact leads nicely into the next difference between the two regions – testing.

Testing

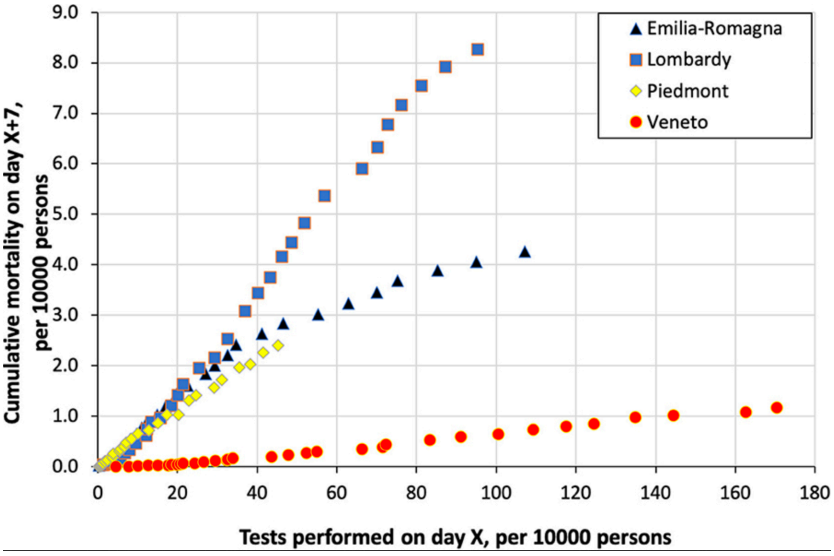
Initially, epidemiological surveillance and swab testing strategies were considered competencies belonging to the regional healthcare authorities (Di Bari et al., 2020). On February 21st, 2020, the two regions of Lombardy and Veneto start tracing Covid-19 patients, testing both symptomatic and asymptomatic people. By February 26th, however, Lombardy decided to only test symptomatic cases (Galizzi and Ghislandi, 2020b) as per the national government's recommendation. See Figure 22 for the cumulative number of COVID-19 tests performed in four regions in northern Italy from February 24th through March 27th, per 10,000 persons in each region and then Figure 23 for the cumulative COVID-19 mortality in the same four regions from March 2nd through April 3rd as a function of the cumulative number of COVID tests performed seven days before, i.e., from February 24th through March 27th.

Figure 22 Cumulative number of COVID-19 tests performed in four regions in northern Italy



Source: (Di Bari et al., 2020).

Figure 23 Cumulative COVID-19 mortality in four regions in northern Italy



Source: (Di Bari et al., 2020).

Di Bari et al. conducted a study investing these two different testing strategies taken within four Northern Italian regions (Lombardy, Veneto, Emilia Romagna, and Piedmont). While Lombardy, Emilia Romagna, and Piedmont followed the stringent policies for swab testing, prioritizing symptomatic patients with possible COVID-19 contacts requiring hospitalization – these recommendations were issued by the Ministry of Health on February 25th - Veneto chose a different route (Di Bari et al., 2020).

President Zaia took on Andrea Crisanti as scientific consultant when the first case was detected,

> *Also known as the 'father of the swabs', Crisanti conducted a well-designed seminal study in the hard-hit municipality of Vo' that informed the global scientific community regarding the best testing-tracing approach. He also informed the international press about the potential burden of asymptomatic transmission, which at that time was still a scientific controversy. His role as science advocate has been pivotal in influencing the testing policy of the Veneto region during the first, strict, lockdown in the early phase of the pandemic (March-May 2020)* (Interviewee 2.20 Public Health Expert).

Veneto kept its original "Public Health Plan" that it had implemented after the first cases in Vo'. This strategy put forth by the Venetian Councilor for Health, Manuela Lanzarin (L) and

supported by Crisanti, followed extensive testing of symptomatic and asymptomatic patients followed by the isolation of positive cases (Regione del Veneto, 2020a). Lanzarin also announced that there would be close cooperation between the regional government and the municipal mayors so that the active surveillance could be intensified (Regione del Veneto, 2020a).

Likely, because of both Crisanti and the "Public Health Plan",

> *The Veneto region managed to implement a test-intensive strategy, not only in the hospitals, but also and most importantly in the community setting. Timely identification and isolation of positive cases of mild severity allowed the regional health system to prevent inappropriate visits to emergency departments, and mostly to reduce the risk of hospital-acquired infections.* (Interviewee 2.18 Medical Professional and Public Health Expert).

In the regions that followed the Health Ministry's orders (Lombardy, Piedmont, and Emilia Romagna),[46] the number of tests conducted were lower than in Veneto, which followed its own, more vigorous testing and isolation strategy. Looking specifically at Lombardy,

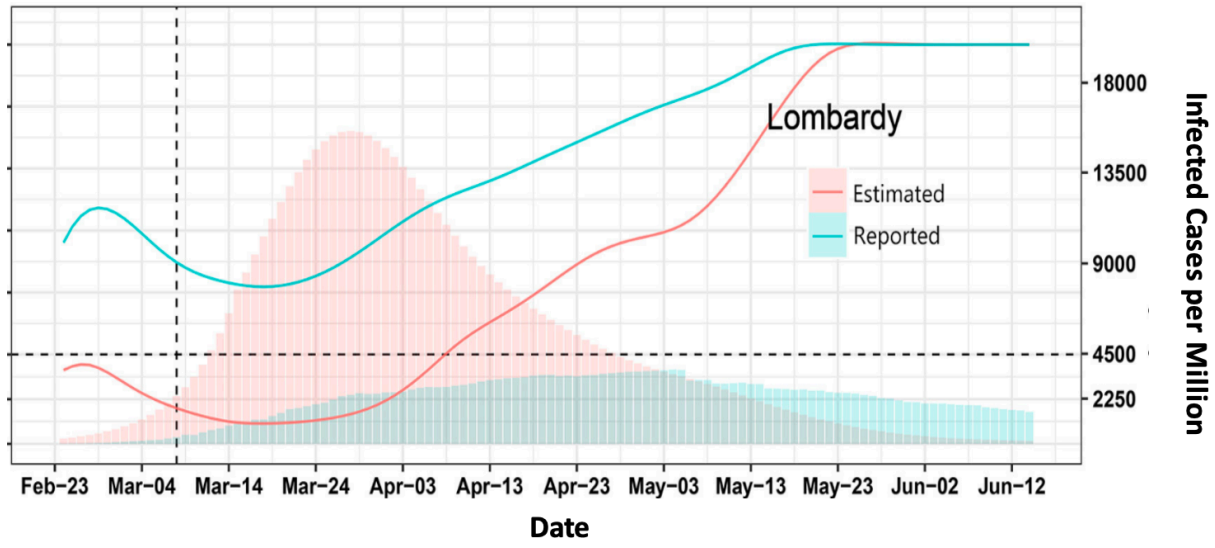
> *A testing system was never implemented in the community setting until May 2020 (regional law 3114, May 7, 2020). This means that close contacts of COVID-19 cases, including the relatives of the victims, and symptomatic persons, were denied tests in the community setting. From a mediatic point of view, citizens felt abandoned and sometimes panicked. The only way to get a test was going to the hospital: the number of visits to the emergency department, including the ones that could have been avoided with a test in the community setting, contributed to the risk of hospital-acquired infection. The lack of tests in the community testing reduced the quality and the effectiveness of contact tracing, a crucial strategy to flatten the curve* (Interviewee 2.18 Medical Professional and Public Health Expert).

[46] Lombardy and Piedmont followed the national government strategy and Emilia Romagna did as well, but with one difference. While Lombardy and Piedmont only tested hospitalized or symptomatic patients, Emilia Romagna also tested asymptomatic cases, but only in specific municipalities (Cicchetti and Gasbarrini, 2016).

As a result, the death rate in Lombardy (as well as in Piedmont, and Emilia Romagna) was significantly higher than in Veneto, suggesting that the Venetian strategy superseded that of the national government. While Veneto effectively contained the virus, the other three regions were helplessly chasing it.

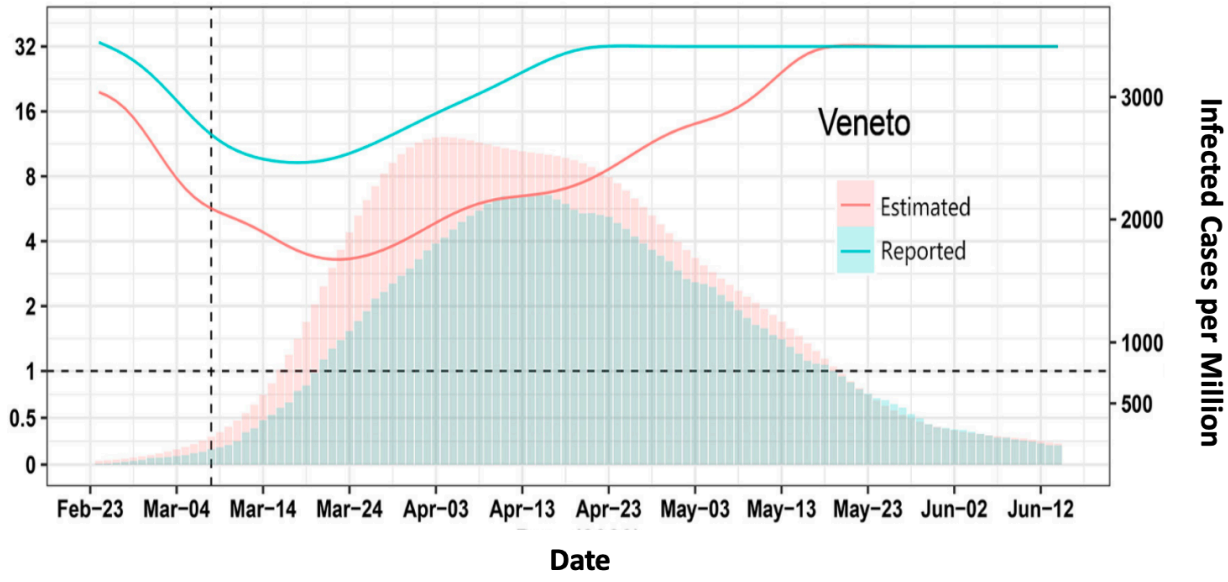
Going back to the comparison between Lombardy and Veneto only, Li et al. conducted a study displaying the difference between reported and estimated cases, thereby proving that testing just symptomatic cases was insufficient (Li et al., 2020). Figures 24 and 25 below display the estimated versus the reported cases in Lombardy and Vento (respectively) during the first few months of the pandemic.

Figure 24 Lombardy: Estimated vs Reported Infections



Note: The green and red bars represent the reported versus the estimated number of infections. Ignore the red and green lines.
Source: (Li et al., 2020).

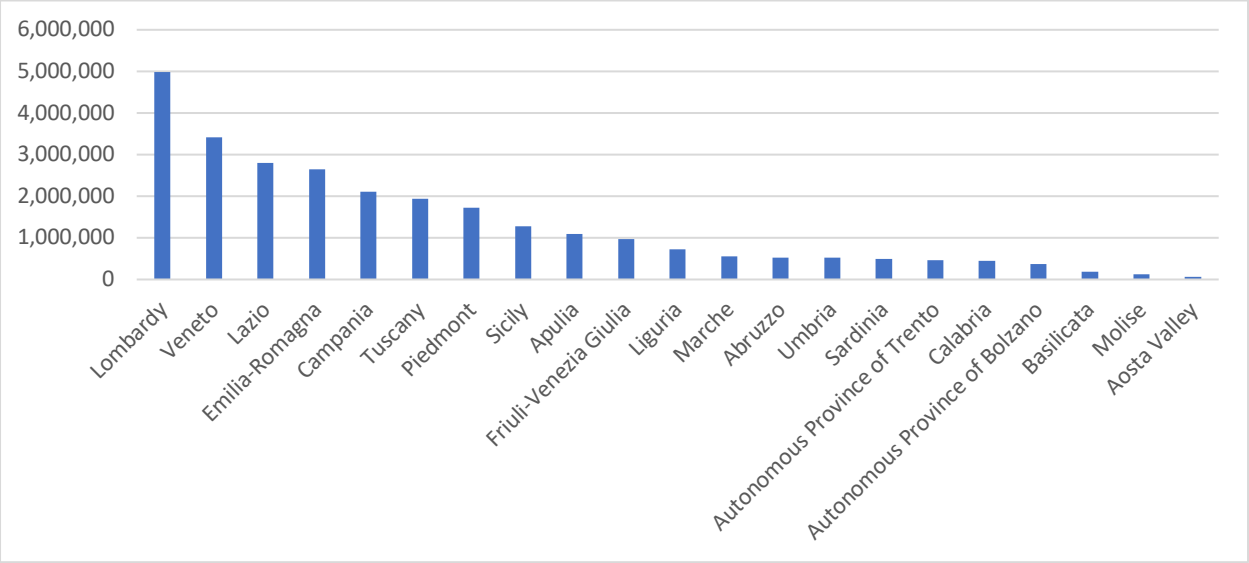
Figure 25 Veneto: Estimated vs Reported Infections



Note: The green and red bars represent the reported versus the estimated number of infections. Ignore the red and green lines.
Source: (Li et al., 2020).

Currently, Lombardy is leading the Italian regions with the number of tests it is conducting (See Figure 26 below); however, it took at least half-a-year to get there. Many people died before they changed their testing strategy.

Figure 26 Coronavirus (COVID-19) tests conducted in Italy as of January 7th, 2021, by region



Source: (Ministero della Salute, 2021).

In addition to obtaining good medical advice and having an efficient plan in place, Zaia himself played a significant role in the region's success with tests:

> *President Zaia associated his personal image with the fight against the pandemic, personally attending TV programs, social events and press conferences. For example, he performed self nasopharyngeal swabbing during a live press release. This strategy has determined a strong association between the results that Veneto Region obtained and the image of the President of the Region who, therefore, came out victorious* (Interviewee 2.19 Medical Professional).

The leadership role that Zaia took on during the first wave of the pandemic garnered him much support not only within his region[47], but within the Lega party. President Fontana of Lombardy had more difficulty:

> *After a first clumsy attempt to expose himself publicly on the media (we all remember at the beginning of the pandemic when, on live TV, Fontana*

[47] Zaia "in the middle of the pandemic" not only saw his "regional government reconfirmed, but he also received a large majority of support from the regional population (about 70% of people preferred him and supported him as president)" (Interviewee 2.20 Public Health Expert).

> *tried to explain how to wear a surgical mask- clearly wrong), he delegated other political figures (Health Minister Giulio Gallera, Vice President Fabrizio Sala) to manage press conferences, appearances in TV programs, etc.* (Interviewee 2.19 Medical Professional)

This strategy of not leading the region and assuming responsibility as President did not serve Fontana well. In fact, it led to the "reshuffling of top medical advisors (i.e., the General Director for Health and Welfare (Luigi Cajazzo) and the Minister for Health and Welfare (Giulio Gallera) were replaced)" (Interviewee 2.20 Public Health Expert).

Hospitals

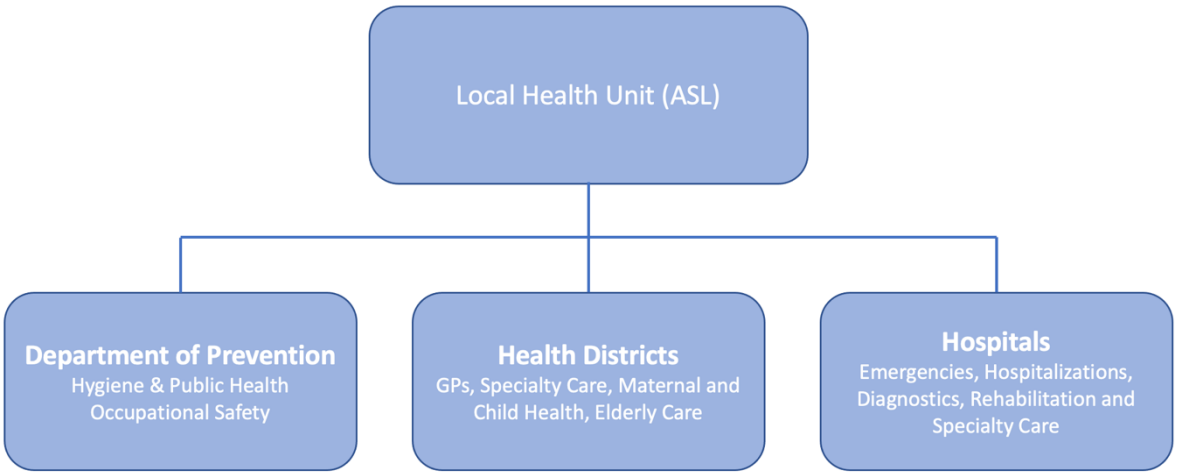
According to a several medical professionals and public health experts, it was not so much a lack of hospitals that presented a substantial problem, rather the lack of a coordinated plan and the resulting flexibility of expansion according to need:

> *The number of hospitals and the accommodation capacity of the intensive care units is adequate to meet the ordinary needs of the local area, but it is also true that one of the missing characteristics of Italian Healthcare System was the ability to expand availability according to needs. In particular, in light of the exponential increase in the demand for beds in intensive care units. It would have been necessary to provide for a plan to expand the number of beds a priori. The lack of an updated national pandemic plan and its regional application led to the need to rely on emergency solutions and clumsy attempts to create new intensive care beds in inadequate facilities, exposing both operators and patients to multiple risks* (Interviewees 2.18, 2.19 and 2.20).

The lack of an up-to-date pandemic plan essentially left each region to fend for itself regarding hospital capacity. As described in the previous chapter, when you look at the hospital situation in the regions, it is important to consider which hospital model each region adopted. According to (Mapelli, 2007) there are four: 1) integrated ASL (local health unit and the center of administrative operations relating to health), 2) separate ASL, 3) mixed ASL, and 4) regional ASL. The integrated ASL is the standard model based on the law 833/78 wherein hospitals and

other hospital services (outpatient clinics, psych services, etc.) are managed and financed by the ASL. The separate ASL, as is the case in Lombardy and represents the complete opposite of the integrated ASL, wherein hospitals have nothing to do with the ASL other than the fact that the ASL pays for the hospitals (public or private). Within the mixed ASL system, some hospitals are contracted with ASLs, and some are not. The regional model is found in the Aosta Valley, Trento, and Molise and just means that there is only one ASL. Figure 27 serves as a reminder of the ASL competencies.

Figure 27 Local Health Units (ASL)



Source adapted from (Mapelli, 2007).

To visualize the differences between these three models, Table 29 summarizes the different aspects, renaming them and adapting them to the pandemic aspects most important in treating the virus.

Table 8.2 Regional Healthcare Models and their differences in dealing with the pandemic

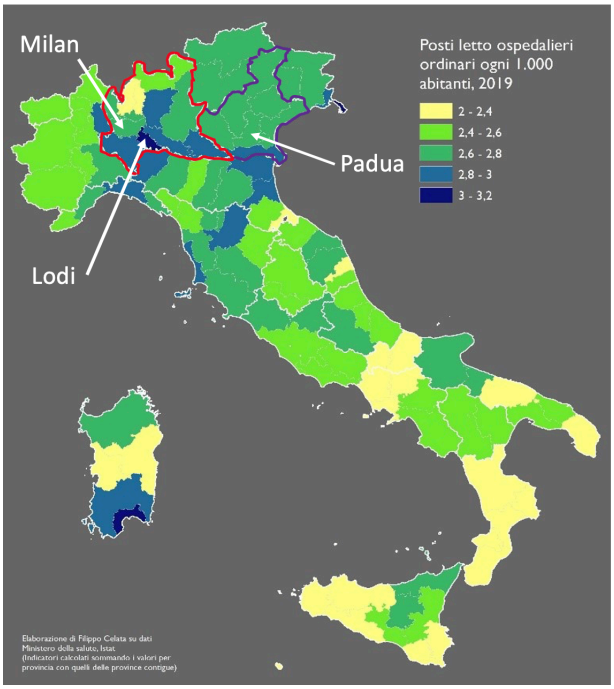
DIMENSIONS	**Hospital Centered Approach** (Lombardy, Liguria, Lazio, Umbria Piemonte, Sicilia, etc.)	**Integrated Approach** (Emilia-Romagna, Marche, Toscana, Calabria, Campania, Valle D'Aosta)	**Community- Home Approach** (Veneto, Friuli-Venezia-Giulia, Puglia, Molise, etc.)
Testing	Used for hospitalized or symptomatic patients only	Diffused in specific territories (symptomatic and asymptomatic patients)	Diffused in the whole region (symptomatic and asymptomatic patients)
Hospital Use	Intensive use > 40%	Intermediate use 20-30%	Limited use < 20%
Primary and community care involvement	GPs active on an individual basis	GPs active in structured mobile teams in collaboration with nurses	GPs active in structured mobile teams in collaboration with nurses
ICUs	Intensively used and rapidly saturated < 15%	Used to support specific contagion outbreaks 10%	Used to support specific contagion outbreaks > 20%
Digital Solutions	Use limited for contract traces	Regional platforms to support Covid-19 patients at home	Local platforms to support Covid-19 patients at home

Source: Adapted from (Ciccetti, 2020).

As shown in the Table above, the healthcare system in Lombardy is built on a hospital-centered approach meaning that the region relies on hospitals, not home care or general practitioners, to care for the sick. In fact, in Lombardy, "GP's are useless. Formigoni introduced this mentality in the mid-90s" (Interviewee 2.176 Economic Sociology and Social Policy Expert). Veneto, on the other hand, is at the other extreme. The region is built on a community home approach wherein hospital use is very limited (less than 20%), and GP's are very active.

The hospital system in Italy, as elsewhere, is the most impacted by the spread of the virus as it struggles to both provide adequate hospitalization for COVID-19 patients suffering from respiratory crises and to continue to treat other diseases. Looking at Figure 28 below, it is clear that most regular hospital beds in the country are located in the North.

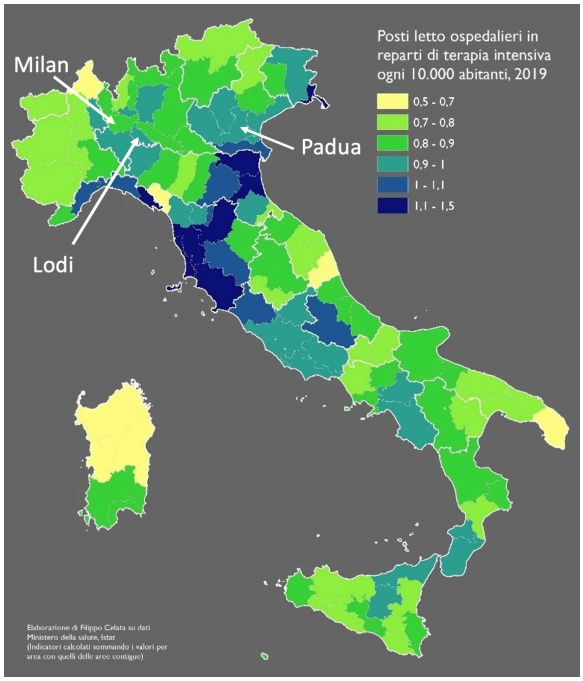
Figure 28 Regular hospital beds per 1,000 inhabitants in 2019, by province



Adapted from (Celata, 2020).

However, it is interesting to note that when looking at Figure 29, most of the intensive care unit beds are located in central Italy and not in the North.

Figure 29 Number of hospital beds in intensive care units per 10,000 inhabitants in 2019, by province



Adapted from (Celata, 2020).

This distinction is important to consider as the treatment for severe COVID-19 symptoms takes place in ICU's. According to OECD data, the number of beds for the treatment of 'acute' cases per 1,000 inhabitants was 10 in 1977, 8 in 1985, 6 in 1995, 4 in 2001, and 3 in 2010 for the entire country. Today, in 2020/2021, this number amounts to about 2.5 (Celata, 2020). This correlates nicely with the trend that hospitals and especially hospital beds are decreasing across countries due to exploding healthcare costs (Garcia-Barbero, 1998; McKee, 2004). This is nicely displayed in Table 30 below, showing the variation of hospital beds between 2010 and 2018 in all Italian regions.

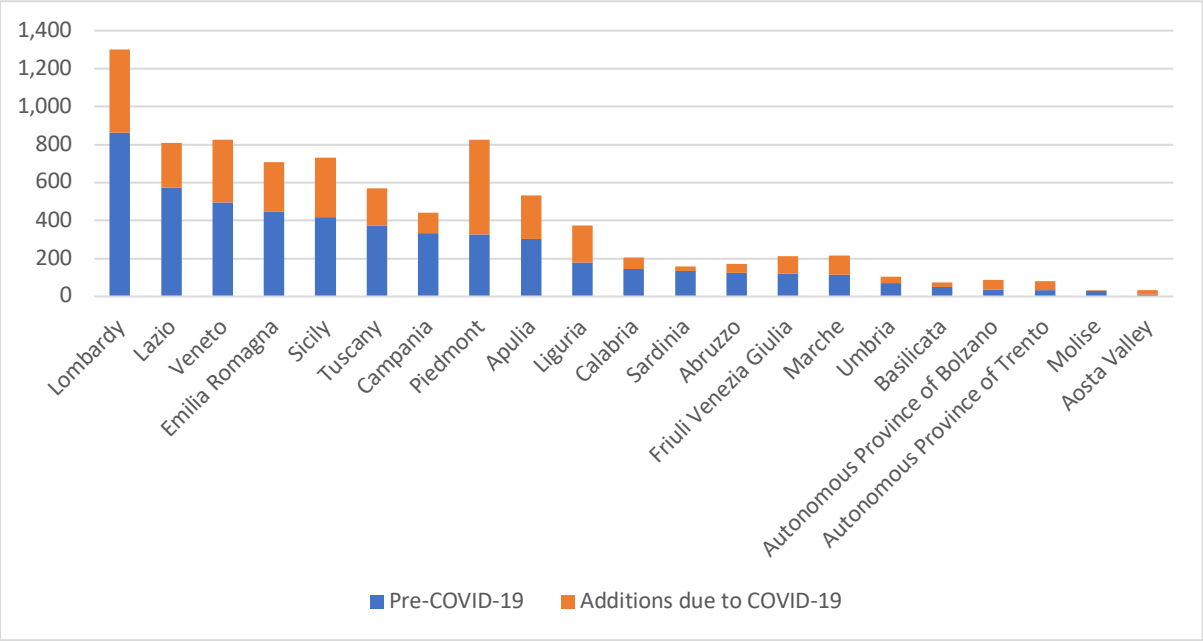
Table 8.3 Changes in the NHS from 2010 to 2017/2018

	Variation of Hospital Beds from 2010-2018		Variation in NHS Personnel 2010-2017		Variation in the number or GPs 2010-2018
REGION	**Normal Beds**	**ICU Beds**	**Medical Staff**	**Nursing Staff**	
Piedmont	-14%	-16%	-3%	-1%	-8%
Aosta Valley	-11%	No Change	5%	11%	-4%
Lombardy	-6%	-3%	-1%	-4%	-6%
Bolzano	-9%	1%	3%	3%	-3%
Trento	-17%	-2%	11%	4%	-13%
Veneto	-7%	-5%	2%	-2%	-9%
Friuli-Venezia-Giulia	-14%	-3%	1%	-3%	-11%
Liguria	-20%	-15%	-28%	-29%	-9%
Emilia Romagna	-5%	-6%	-5%	-2%	-9%
Tuscany	-17%	-9%	No Change	-2%	-11%
Umbria	-2%	-3%	6%	1%	-5%
Marche	-19%	-12%	-1%	No Change	-8%
Lazio	-12%	-9%	-22%	-11%	-10%
Abruzzo	-13%	4%	4%	-4%	-3%
Molise	-29%	-16%	-34%	-16%	4%
Campania	-13%	-6%	-18%	-13%	-2%
Puglia	-19%	-10%	-6%	-6%	No Change
Basilicata	-16%	-11%	-2%	No Change	-2%
Calabria	-29%	-16%	-15%	-10%	8%
Sicily	-13%	-11%	-5%	8%	-5%
Sardinia	-21%	-28%	16%	13%	-12%

Adapted from (Celata, 2020).

In Lombardy, the pre-crisis total ICU capacity was approximately 720 beds (2.9% of total hospital beds at a total of 74 hospitals); these ICUs usually have 85% to 90% occupancy during the winter months (Grasselli et al., 2020). As can be seen in Figure 30, both Lombardy and Veneto had to increase their ICU capacity. However, Lombardy had to increase its capacity at a bit more than Veneto.

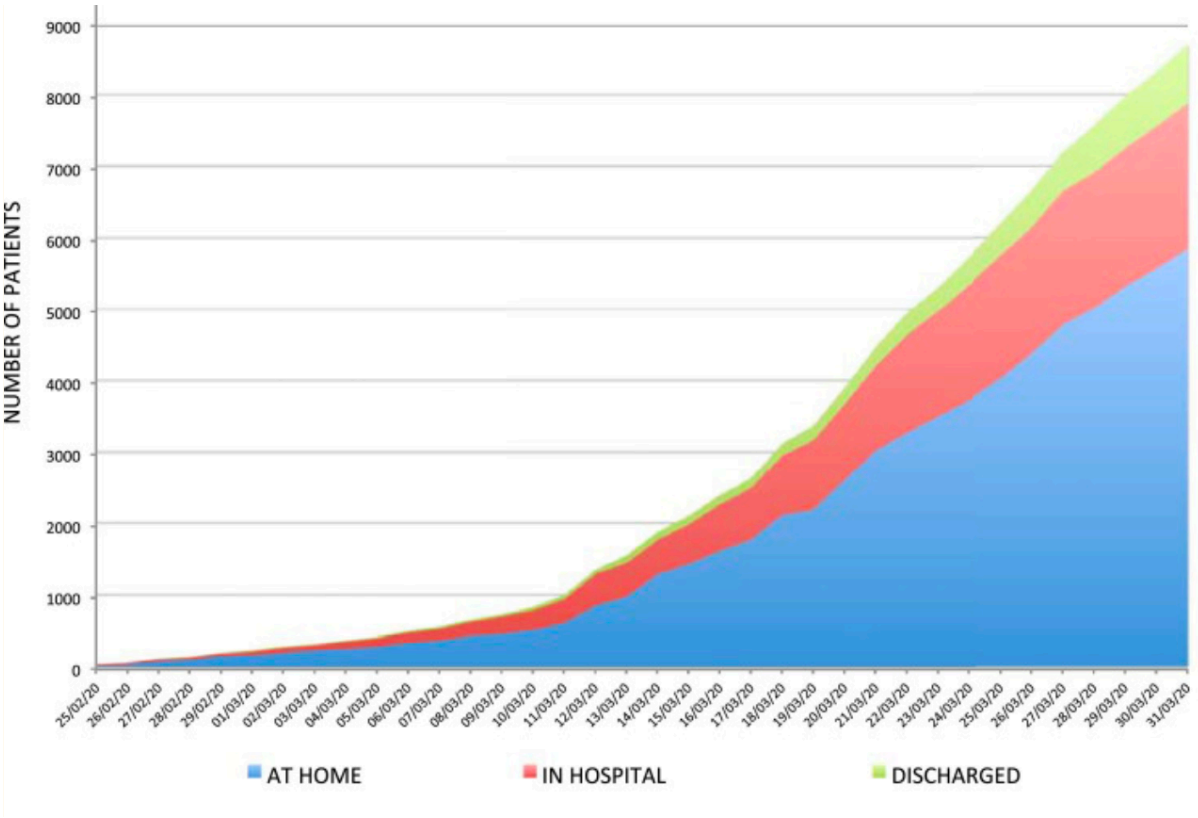
Figure 30 Number of intensive care units (ICU) pre-and post-COVID-19 in Italy as of April 2020, by region



Source (Corriere della Sera, 2020).

The reason for this additional increase was likely due to the fact that Lombardy, being heavily reliant on hospitals for care, did not have a community care network to fall back on. While Lombardy had the most intensive care units in the country (861), it had to increase these by 50% (438) (Michas, 2020)due to not only the high number of cases in the region but also because the region followed a hospital centered approach to healthcare. On the other hand, Veneto had a total of 438 beds across 36 hospitals totaling 1 ICU bed for 11,200 inhabitants. Over the course of three weeks, the region increased its ICU capacity by 71% (Pasin et al., 2020) due to the data arriving from China reporting a 5% ICU admission rate (Xie et al., 2020). What ended up happening was that most patients did not need to be hospitalized and were able to be cared for at home because of the strong community home healthcare approach in Veneto. In fact, only 35.2% (3,487) were hospitalized, and of those, only 10% need to be treated in the ICU (See Figure 31 below) (Pasin et al., 2020).

Figure 31 Number of coronavirus-2019 patients in Veneto from February 25th to March 31st, 2020



Note: The blue area represents the number of COVID-19 patients managed at home. The red area depicts COVID-19 patients requiring hospital admission. While the Green area shows the discharged.

While hospital treatment is important with regards to the pandemic, it is not the only tool available. Ideally, contact tracing and testing would be so widespread that hospital admissions are necessary only in the rarest of cases. However, because the pandemic spread quicker than officials were able to keep up with testing and contract tracing, the number of hospitals and ICU beds became an increasingly important statistic. A further fact that is often neglected is the number of medical personnel available. Both medical professionals and public health experts commented on a lack of personnel and a lack of appreciation in the form of monetary compensation:

> *I have worked in the National Service since 2014. Well, the salary for the people working with the national health service has been frozen up since the*

> *beginning of the millennium. Our, our, power, our salary is the same since 2000. Medical professionals are continuously requesting increasing in wages but, the government has always avoided this* (Interviewee 2.6 Medical and Public Health Expert).

As a result of the limited financial incentives, there is a:

> *Huge lack of specialists in Italy, and that they are not increasing the grants for specialization, so every year, the government says we have xxx € for ten anesthesiologists, ten cardiologists, etc. This year (2020), there has been a lack of 9000 grants, so there is a lack of doctors everywhere, and that is a huge issue. That is why they had to call back medical professionals that were already retired* (Interviewee 2.12 Medical Professional).

It has long been known that in order to cut health care expenditures, caps were put on medical personnel expenditures (Neri, 2019), leaving health professionals underpaid. Even before the COVID-19 pandemic, regional health authorities were suffering from shortages of medical practitioners and wanted the national government to recruit retired doctors (AFP/The Local, 2019). Italy is not the only a country with elderly physicians, but it also has an uneven distribution of training programs across the country's regions, making it difficult for young people to become doctors; not to mention the bias towards choosing a medical specialty (Colombo and Bassani, 2019). So, not only are Italy's physicians underpaid, but very few people want to do the job, thereby leaving hospitals understaffed and personnel over-worked. During a pandemic, this combination of a high number of COVID-19 cases (Lombardy and Veneto) with insufficient hospital staff for a hospital centered health system approach (Lombardy) has led to the particularly high mortality rate that can be seen in the region of Lombardy (26,789 deaths) compared with that of Veneto (8,695).

Conclusion

The COVID-19 pandemic displays an interesting and practical application of the theory that PRR politicians have a limited and oft skewed understanding of health. While this theory is confirmed in both national cases, it does seem to apply in the subnational case of Veneto. To summarize, I briefly looked at the reactions of the two PRR parties in opposition on the national level in both Austria and Italy. I skipped the subnational cases of Austria as there were no PRR politicians in power or in opposition. Then I moved directly to investigating the subnational cases of Lombardy and Veneto.

On the national level, the Austria and Italian PRR parties (FPÖ and Lega, respectively) moved from wanting to close the country's borders and suspend Schengen at the beginning of the pandemic to protesting the wearing of face masks as inefficient and freedom robbing by the end of the 1st wave in Summer 2020. In between the onset of the pandemic, after the borders were closed, and shortly before the first wave ended, both parties were reasonably quiet. The FPÖ supported governmental decisions, and Matteo Salvini seemed to have disappeared completely. Come summer 2020, both found their voices again and protested government actions in their own ways. The FPÖ continuously criticized the Minister of Health's inability to formulate laws that made sense. At the same time, the Lega continually accused the government of favoring immigrants, whom the Lega and FdI blamed for the spread of the virus in the first place, over Italian businesses. By the beginning of the second wave in the Fall of 2020, both parties captured the public sentiment surrounding "corona tiredness" and began pushing for a "return to normalcy". Especially the FPÖ began criticizing the government for leading the country towards bankruptcy and demanded the immediate reopening of businesses, restaurants, and hotels. When vaccinations were ready in December, both parties protested forced vaccinations and disadvantages for citizens that refused to vaccinate. While these are all very

strong opinions, they are opinions coming from the opposition and do not tell us how these parties would have acted in government. Therefore, I looked subnationaly.

In Austria, Carinthia and Burgenland, as well as the other seven provinces, do not have FPÖ members present in their regional government; therefore, these potential cases were excluded. In Italy, however, the Lega was and is in government in Lombardy and Veneto, thereby making those compelling cases.

Both Lombardy and Veneto had and continue, for the most part, to have the most cases in all of Italy. Their approaches to the pandemic, especially in the beginning, were, however, very different. Right from the start, Veneto made a powerful and unified appearance under regional president Zaia communicating that it was essential to follow the rules of the central government. After the outbreak in the municipality Vo' in Padua, Zaia enforced a strict contract tracing and testing strategy for symptomatic as well as asymptomatic people. This strategy, along with its community-centered health systems approach, quickly decreased the number of cases in the region and sharply decreased the first wave's mortality rate.

The region of Lombardy under regional president Fontana had a more difficult time keeping all of its provinces on the same path. While the province of Lodi entered into a strict lockdown after an outbreak was discovered, the bordering province of Milan made no concessions. The mayor even announced that the province would not close. These decisions, along with choosing a hospital-centered health system approach and only testing symptomatic cases, caused the region's numbers to explode.

Leadership, communication, but most importantly, the existing organizational characteristics of the region's health system played an enormous role during the first wave of the crisis, while partisanship played almost no role. Since it is not yet certain when the pandemic's

2nd wave will end, I feel it is too speculative to make any concrete remarks. However, it is already clear that previous strategies seemed to play less of a role in containing the mutated form of the virus, B1.1.7, which was already circulating amongst residents in the winter of 2020.

Chapter 9 : Discussion and Conclusion

Summary of Findings

Populist Radical Right (PRR) parties are increasing in political importance across Europe and throughout the world. What we know about this party group is how they think about migration, security, immigration and, in part, welfare policies. These topics have been well documented within research surrounding manifestos (Rooduijn et al., 2014, Careja 2016, Heinisch 2019 & 2020). We know less about what kind of policies these parties implement when given a position in government. Some researchers have focused on this gap (Afonso 2014, Ennser-Jedenastik, 2018, Röth et al., 2018), but the specific topic of healthcare as an essential part of the welfare state has found little uptake in this body of literature.

This research is crucial because past performance or the types of policies a party has previously passed can often be used to predict future political decisions (Lebas and Euske, 2002). Politicians, the electorate, and healthcare professionals stand to benefit from such an analysis because it will improve decision-making for policy delivery, election outcomes, and healthcare distribution. By expanding on the research relating to the political determinants of health as well as the social and welfare politics as they relate to health policy, outcome prediction will improve. When thinking of health policies, who is in government and how the health policies might change because of the ideologies associated with the party in power is exceptionally relevant. Being able to anticipate what these parties will do is fundamental not only to health and political science research but also to countries on the verge of elections.

So, how do PRR parties approach health policies when given a position in government? This dissertation found that elements of welfare chauvinism, increasing benefits for the native population while simultaneously decreasing them for the outgroup, were common within the health policies passed by the PRR in government. The effectiveness of these policies depended on two fundamental variables: 1) the coalition partners willingness to agree to such policies and 2) the strength of the institutional courts within the country.

The willingness of the coalition partner generally depends on tow aspects: their strength and their political orientation. This implies that the coalition partner is typically stronger than the PRR party, which often makes it difficult for the PRR party to implement its desired policies. In most cases, however, PRR parties form coalitions with a stronger center right party. With such a constellation, the PRR party often finds support for their proposed health policies.

The second approach that PRR parties in government were found to take is the liberal chauvinist one. Policies following this approach typically decrease benefits for all with the strongest impact on outgroups. While the PRR's welfare chauvinist policies were often hindered by constitutional rulings as well as by an unwilling coalition partner, liberal chauvinist policies were generally supported by the coalition partner (if of conservative orientation) and rarely ever questioned by the courts. As previously mentioned, Conservative, or center right parties, most often form coalitions with the PRR. In such cases liberal chauvinist policies, also within the realm of health, are not uncommon as they serve the interest of both political parties: a decrease in spending (conservatives) while also making life more difficult for outgroups (PRR).

Countries like Austria, where health policies are primarily made on the national level, will find that the PRR can have a greater impact when they hold positions in the national

government. On the other hand, countries like Italy, where healthcare has devolved to the regions, it makes more sense to look at PRR health impact on a regional level.

Findings from the National Level

On a national level and the subnational level, as the next section will further explain, the cases of Austria and Italy differed substantially in their competencies surrounding health. Given that in Austria, most health decisions are concentrated at the national level, it is not surprising that the influence of the PRR on health policies was more significant than in Italy, where most health decisions were devolved to the regions.

The FPÖ in Austria influenced health outcomes directly via the health policy decisions they proposed and partially were responsible for implementing. One of the FPÖ's primary goals concerning health politics was to strengthen the power of the government while simultaneously weakening the influence of institutions outside of the government structures, also involved in healthcare decisions. Therefore, it makes sense to divide the FPÖ influence on health into two categories: 1) structural reforms of the health system such as the social insurance merger and the introduction of a private hospital financing fund and 2) policy choices targeting behavioral outcomes, such as the introduction of new e-cards and the reversal of the smoking ban.

The structural health reforms took on welfare chauvinist, and liberal chauvinist characteristics, wherein the liberal chauvinist approach was more prominent, very likely due to the close involvement of the ÖVP. These structural reforms were critical because they gave the FPÖ increased influence within healthcare structures (Haider's initial goal in the '90s). The ultimate result of the healthcare merger was the breakdown of the SPÖ stronghold in all things concerning health. Thus, the FPÖ and the new ÖVP could now position key players within the newly created

health insurance company ÖGK (resulting from the fusion of the nine regional health insurance companies).

Looking at the other structural reform initiated by the FPÖ, PRIKRAF, or the private hospital reform, we see just how prominent clientelism continues to be within the political realm. Accusations of clientelism were also geared towards the new ÖVP implying that clientelism is not only a PRR problem, rather one that is deeply embedded within the structures of the political system in Austria, as well as in other countries, no doubt[48]. This reform was not only problematic because of its highly clientelistic nature but also because much of the money that was used to support the private hospitals is paid for by patients' contributions. In addition, those insured through the ÖGK (Austrian Health Insurance) contribute a significant amount of money to the PRIKRAF fund, but they only use 50% of the beds; the rest are used by the self-employed and civil servants (covered by a different insurance company). While this reform can be considered clientelistic, it also has a hidden welfare chauvinistic flair to it. The FPÖ, more often than not, sells itself as a worker's party catering to those that see the brunt of globalization. The FPÖ, however, is also a party that caters to the *Burschenschaften* (traditional student fraternities), primarily made up of wealthy, incredibly right-leaning educated FPÖ voters. By modifying the PRIKRAF to include more private hospitals, the FPÖ was pampering its much smaller electorate. by increasing the welfare benefits of those that can afford private insurance on top of the mandate for public insurance while potentially decreasing benefits for all non-privately insured Austrians covered by the ÖGK.

[48] The new ÖVP's clientelist appetite can be seen in the court cases surrounding the trading of political offices for favors and false statements in court Finance Minister Blümel (new ÖVP) and Chancellor Kurz (new ÖVP) are currently (2021) involved in.

The reforms instigated by the FPÖ that target individual behavior can be classified as welfare chauvinist regarding the e-card changes and anti-science with respect to the overturned smoking ban increased corona measures and a general lack of support for vaccinations. While several of the health policy reforms passed were done so with the help of the new ÖVP, the FPÖ distinguishes itself from its conservative coalition partner by also putting forth policy decisions that sharply contrast scientific evidence. The most important example is the FPÖ's role in overturning the smoking ban, which the former SPÖ-ÖVP coalition had introduced. Against overwhelming scientific evidence, the FPÖ portrayed itself as the protector of small business owners and ordinary people propagating individual choice over top-down regulations.

In summary, the FPÖ's policy choices incorporate both clear markers of well-known PRR characteristics as well as elements influenced by its conservative coalition partner. Favoritism towards the native, ordinary people and the systematic exclusion of foreigners from health and social services eligibility is a common FPÖ policy mantra, even with regards to health. Examples can be found in the introduction of a photo-based e-card, the new minimum income law, or the Family Bonus Plus regulation. Also, in line with conceptualizations of PRR parties is the liberal chauvinist approach coupled with anti-elitist sentiments, which became apparent in the structural reform of the health care system. The legitimization of this reform, which the ÖVP actively supported, created a system "closer to the ordinary people." However, it decreased the representation and thus the self-administrative power of the worker group, represented by established labor organizations. The short-term "aims" appeared to reduce bureaucratic costs and relieve the SPÖ of their monopoly in all things health. The long-term aim will presumably result in more bureaucracy (we see this already), which will lead to higher costs to run the health

insurances (already happening – need governmental support) and will very likely result in a decrease in services for the insured.

The anti-elitist/anti-science nature of the FPÖ's policy preferences also manifested in its harsh opposition to stricter anti-smoking laws and increased corona measures. This type of "science populism" is common in PRR parties. In this case, the FPÖ propagated the interest of particularistic groups (smoking customers and small bar owners) while ignoring the advice of public health authorities. Although in opposition during the corona pandemic, the FPÖ went from approving the government's strict measures in the Spring of 2020, at times even saying that the actions were not severe enough, to finding the measures exaggerated and unnecessary by summer 2020. Upon the onset of the 2nd wave in the fall of 2020, the FPÖ settled on criticizing the government's lack of cohesion and their inability to present clear and legally sound measures.

As expected, Lega politicians' health policies passed or supported in Italy were fewer, given that health policies are typically made at the subnational level. The policies made on the national level can be summarized as being typically Conservative due to the strict debt containment measures during the Berlusconi coalitions (II-IV) and welfare chauvinistic coupled with anti-scientific rhetoric during the Conte government (I). While the LN was not able to directly pass health policies during the Berlusconi coalitions, they supported the retrenchment measures proposed during the second Berlusconi government. During the third Berlusconi government, the LN also supported further healthcare retrenchment efforts and attempted to reduce access to healthcare for undocumented migrants indirectly through the security laws.

During Conte, I, the anti-scientific vaccination rhetoric and the welfare chauvinistic policies passed in the Salvini Decree dominated the short-lived government. The already difficult

situation surrounding the corona pandemic in Italy was made even more difficult due to the Lega's consistent criticism of the government, their attempt to uphold anti-immigrant sentiments by blaming migrants for importing the disease, and their inconsistencies regarding the wearing of masks.

PRR politics in Italy and elsewhere, can generally be summarized as having a lot of bark but no bite. This was formulated more eloquently by Anna Cento Bull when she described the politics of the Lega as "a form of political communication that articulates demands which are not supposed to be taken seriously and implemented, but which are nevertheless constantly rearticulated" (Bull, 2010, 431). This is to say that manifestos and rhetoric are filled with action points; however, these can be counted on one hand when it comes to implementation policies. In fact, in Italy, health policies, as with other policies, are only tampered with when necessary (i.e., the COVID-19 pandemic). Otherwise, they are left alone as there are too many consequences associated with negative outcomes.

Findings from the Subnational Level

The subnational sections have demonstrated how two prominent and popular PRR parties (the Lega in Italy and the FPÖ in Austria) have influenced health politics at the subnational level. The findings establish that the magnitude of PRR influence on health depends on who parties form coalitions with, how much authority they are actually given within the local health ministry, and what institutional structures are in place.

Based on the literature surrounding the consequences of PRR parties and their approach to social policy, the expectation was that these parties would also pursue welfare chauvinistic

policies regarding healthcare. While this is most certainly in line with their intentions, this section found that the PRR parties in subnational governments were generally unable to pass desired policies or even attain a position where they could pass such policies due to coalitional and institutional constraints.

While the FPÖ in Austria followed a mostly welfare chauvinistic approach to health during its time in national government (2017-2019) (Falkenbach and Heiss, 2021), the same could not be said for the subnational consequences. To begin with, in Austria, health policies are mostly made at the national level, so it was expected that the influence on a subnational level would be less. Secondly, in both Austrian cases (Burgenland and Carinthia), the FPÖ did not control the health resort. In Burgenland, this occurred because the FPÖ was simply the weaker coalition partner. In Carinthia, the situation was slightly different. Although the FPÖ did not control the health sector, they attempted to reform the hospital structures due to their prominent role on the hospital advisory boards. The FPÖ goal was to cut hospital expenditure through closures, mergers, or simply by slimming down bureaucratic structures to redirect funds to support their "Carinthian's first" mentality. Thus, while it appears that the Carinthian FPÖ was taking a typically conservative retrenchment approach, they were attempting to cut in one area (hospital care) so that they could redistribute to other (social policies, labor market activation, tourism) sectors. In essence, the argument can thus be made that the Carinthian FPÖ took an indirect welfare chauvinistic approach to health. They attempted to redirect funds to sectors that they controlled, thereby increasing benefits for some while decreasing them for others. What ultimately hindered the Carinthian FPÖ from being successful was the strength and resilience of their coalition partner, the SPÖ.

In the cases of Italy, the two Italian regions of Lombardy and Veneto followed similar political trajectories in relation to health. Both regions were in the hands of the center-right Forza Italia (FI), beginning in 1995 until at least 2010 when Lega Presidents took over. Despite having the same parties in power, their healthcare systems developed much differently and with very contrary foci.

In Lombardy, President Formigoni (FI) created a healthcare system unique to Italy. He followed a quasi-market model wherein patients could choose whether they wanted to use public or private hospital facilities. The system he created revolved around the hospital as the center for care, thereby deeming a general practitioner (GP) useless. The result was an unbalanced system as only hospital care was given support. Formigoni's successor, Roberto Maroni (Lega), realized this and attempted to balance out the system. After several failed attempts to move care outside of the hospital to accommodate the growing elderly and chronically ill population, his term ended. An even less successful Attilio Fontana (Lega) took over as President of the region in 2018. A weak presidential presence coupled with ineffective advisors and an ill-equip system led Lombardy to become the poster child of pandemic failures during the 1st wave of the COVID-19 outbreak. The failure of the Lega to change the Lombard health system can be primarily attributed to institutional barriers.

In Veneto, Giancarlo Galan (FI), uninfluenced by the ultra-conservative catholic movement (*Comunione e Liberazione*), created a more integrated healthcare system. Four levels of care created a more balanced system wherein the GP was given the traditional role of gatekeeper and seen as an essential part of the system. The historically more communal and interconnected region made it necessary to create a connected and more community-oriented

healthcare system. When Luca Zaia (Lega) replaced Galan in 2010, he expanded this system, making it even more patient-centered and organized. Unlike his colleagues in Lombardy, he did not see the need to change the existing system as it worked well. This efficiency was supported during the pandemic's 1st wave when despite being a very impacted region, case numbers and deaths tolls were marginal compared to those of Lombardy. It could be argued that the Lega in Veneto were also presented with institutional barriers in the sense that they had to continue with the health system they were given because it was effective, efficient, and well-liked by the populace. So, while they might have wanted to make changes, they did not because the system was successful.

Findings Across Cases, Contributions, and Lessons

This research contributes to the literature surrounding the impact of PRR parties in government. It not only looks at the understudied area of health impact, but it does so on both a national and subnational level. Both the consequences of PRR governments on health and health policy as well as the focus on subnational PRR governments expand the perspective of PRR study. The findings affirm that party's matter when thinking about policy impact and suggest that PRR parties are generally constricted by either their coalition partner (as was the case in Austria) or institutions (as was the case in Italy).

Successful implementation of PRR policies, specifically regarding health, can be seen in the national case of Austria, where the coalitional constraint was removed as the ÖVP in 1999, and the new ÖVP in 2019 readily supported the FPÖ's proposed changes. Only institutional barriers stood in the way. Typically, these institutional barriers surrounded the social policy changes that the FPÖ proposed, deeming them unconstitutional, against human rights, or not in

line with EU laws and regulations. Frequently these barriers also surrounded accusations of clientelism and corruption.

Looking beyond the six cases presented here, there are lessons to be learned for countries dealing with strong PRR parties. The first lesson is that it is often better to give the PRR party a position in government than to keep them in the opposition. Both on the national level (1999) and subnational level (Burgenland) in Austria, the FPÖ was given a position in the ÖVP and SPÖ (respectively) governments as a minority coalition partner. By taking the FPÖ out of the opposition, there was less critic against the government, the ÖVP and SPÖ could mostly follow their own political programs without substantial influence from the FPÖ since they were in the minority and, most importantly, internal conflicts, especially at the national level, destroyed the FPÖ. This strategy likely only works when the PRR party in question has never been in government before, as the second ÖVP-FPÖ coalition in 2019 went much better for the FPÖ until corruption scandals forced the FPÖ ministers to step down.

The second lesson surrounds institutions. If a country has strong, established institutions, independent courts, and an engaged civil society, PRR policies that can be classified as being directly welfare chauvinistic are generally deemed unconstitutional in some way, shape, or form. Similarly, accusations of clientelism and corruption are taken seriously and typically result in the dissolution of the government and the political end of the accused. We have witnessed this several times in Austria. However, the current situation with Minister Blümel and Chancellor Kurz is alarming, seeing as both are refusing to step down from their positions despite being accused of corruption and false testament. In Italy, the situation is slightly different as the legal system and the approach to corruption are questionable, making the standards that politicians are

held to equally questionable (best example Silvio Berlusconi, not to mention the power and influence of the Mafia).

A third lesson revolves around the strength and the number of coalition partners in any given government (national or subnational). The higher the number of parties in any one government, the less strength any one party has, in general. Looking at the Italian governmental coalition from 2001 to 2006 with Silvio Berlusconi (FI) as Prime Minister, the government was made up of the Conservative Forza Italia (FI), the PRR Lega Nord (LN), the PRR National Alliance (AN), the Conservative Union of the Center, the Conservative Christian Democratic Center and the Liberal Democratic Foundation. Each of these party's had at least one ministerial position, with FI holding nine ministries including the PM, the LN holding six ministries along with the deputy PM, the AN holding six ministries along with the deputy PM, the Union of the Center, and the Christian Democratic Center each holding two and the Liberal party holding one ministry. With such a dispersal of power, it is difficult for any one party to have complete control. However, the party with the most ministries (generally also the party holding the Chancellorship or the PM), in this case, the FI, will likely have more say than the other parties. A completely different scenario arose in Italy in 2018 when the Lega and the Five Star Movement (M5S) won the election. The two parties split the ministerial position, each attaining nine ministers and the heads of both parties becoming deputy PM. The PM, President Conte, in this coalition was independent, as were six other ministerial positions. Here, the PRR Lega was given more freedom to govern as the coalition partner (M5S) was their equal in power.

Specifically, in terms of health, the color of the coalition partner matters greatly. Here, it makes sense to look to Austria as, on a national level, the FPÖ was only ever in government with

the Conservative ÖVP, a party that is not known for making health policies. Thus, in such a case, the likelihood that a PRR party has control of the health sector is high, allowing them to impact health significantly. If, on the other hand, we look to the subnational level, we see that both in Carinthia as well as in Burgenland, the FPÖ was in a coalition with the SPÖ. The Social Democratic SPÖ, as was previously mentioned, is known for being actively involved and making health policies. Thus, it is of little surprise that the FPÖ had little influence on health in both provinces as this sector was always in the control of the SPÖ.

A further lesson for consideration is surrounding the cultural makeup of a country, province, or region in establishing the potential success that a PRR party has in that area. Whether a PRR party or politician comes to power, at least from a subnational standpoint, depends a lot on the historical make-up and development of that region or province. In Austria, I showed two different cases Burgenland and Carinthia, both had the FPÖ in government, but then in the latter province, the FPÖ was much more successful. This was mostly due to the historical development of the province and the animosity between Slovene minorities and Carinthia's fueled by WWII. The cultural clashes in a province like Carinthia coupled with the general sentiment that previous governments (SPÖ led) were not hearing the plights of the population led to a perfect breeding ground for populist sentiment and the rise of the FPÖ.

In Italy, the regions of Lombardy and Veneto also had their historical and cultural differences leading to very different PRR leaders. The Lombardy region was more influence by the market-driven and oriented Forza Italia with close ties to the ultra-Catholic *Comunione e Liberazione*, making it very difficult for the Lega to follow through on their agenda. On the other hand, the community-oriented, small and middle business populated Veneto with its desire to

upkeep the Venetian language and culture gave the Lega more political and institutional room to become successful.

The findings in Lombardy and Veneto were rather unexpected as one would assume that political parties have similar interests thereby attempting to create unified systems. It is surprising that the FI party, created two completely different systems leading one to believe that it is not only parties that influence the creation of systems, rather, perhaps more so, the history and traditions of the region.

A final lesson that leads nicely into the next section entitled Future Research involves the capacity of PRR parties in government to make their ideas more mainstream. Even if PRR parties fail, their ideas are often adopted by mainstream, usually Conservative, parties. I showed that the Lega's capacity to influence policy-making during its years (especially initial years 2001-2006) in the national government was rather limited. However, the impact that the Lega has had on the Italian political culture has been extremely significant. For example, the desire and need to transform Italy into a federal country, a traditional LN issue, is now accepted by mainstream political parties. In addition, the issue of security has now become a relevant political issue for all the political forces.

In Austria, we have seen the same development. Conservative parties such as the ÖVP, and even more so the new ÖVP, have adopted the FPÖs positions with regards to immigration, migration, integration, and security, making what used to be non-issues issues that win elections.

Future Research

On both a national and subnational level, future research would do well to investigate the new ÖVP, considering the FPÖ's political standstill due to the Ibiza affair and the dismissal of Heinz Christian Strache as a member of the FPÖ. The new ÖVP has, in part, taken over the FPÖ's position on the political spectrum while keeping up their Conservative appearance.

Given the current political situation (2021), where the new ÖVP have formed a coalition with the substantially weaker Green Party who also happen to control the Ministry of Health, future research should look at how much influence the new ÖVP has within the Green Health Ministry. Considering the COVID-19 pandemic and its further unfolding, my guess shows a new ÖVP that wants credit and control of everything when things are going well and finds officials to blame and get rid of[49] when outcomes turn sour.

Future research on the PRR in Italy should continue to follow the Lega but also keep an eye open for Giorgia Meloni's Brothers of Italy. This increasingly popular PRR party could be placed to the right of the Lega on the political spectrum. In addition, health policies in the country might be better studied on a regional level seeing as the devolution of the health system has left the national competencies rather sparse.

While this dissertation has covered the COVID-19 pandemic in terms of the Lega's political impact in Veneto and Lombardy, this should be expanded to other regions in Italy and compared with countries that have a similar political constellation and devoluted healthcare system as the Italian one.

[49] Clemens Auer previous advisor to former Health Minister Anschober (Green) was relieved of his post due to supposed poor decisions-making with regards to vaccination acquisitions for Austria. Former Minister Anschober resigned due to health issues caused by the stress of feeling unsupported by his coalition partner (new ÖVP).

Appendix A: Interview Coding Protocol Austria and Italy

Table A.1 Interview Coding Protocol Austria

Theme / Codes	Notes
1. FPÖ	
1.1 Health in all Policies	
1.2 Federal	
1.2.1 Social Policies	
1.2.2 Health Policies	
1.2.3 Migration	
1.3 Party	
1.4 Burgenland	
1.4.1 Health	
1.5 Carinthia	
1.5.1 Politics	
1.5.2 Migration	
1.6 EU	
1.7 Vorarlberg	
2. Federal	
2.1 Politics	
2.1.1 ÖVP	
2.1.2 SPÖ	
2.2 Social Policy	
2.3 Health Politics	
3. Politicians	
4. PRR Parties in General	Not Austria specific
5. The dark side of parties	Austria Specific
5.1.1 reduced generosity	
5.1.2 increased generosity	
6. Healthcare System	
6.1 Financing AT	National level
6.2 Reforms AT	Health reforms on a national level
6.3 Carinthia	
6.4 Burgenland	
7. History	

7.1 World	History of the world as it impacts Austria
7.2 Austria	
7.3 Carinthia	
7.4 Burgenland	
7.4.1 Population	
8. Carinthia	
8.1 SPÖ Politics	
8.2 ÖVP Politics	
9. Burgenland	
9.1 SPÖ Politics	
9.2 Migration	
9.3 SPÖ vs FPÖ	Differences between the SPÖ and FPÖ in the region and why it matters
10. Carinthia vs. Burgenland	Specific contrasting features mentioned
11. Vaccination	Federal level
12. Electorate	
12.1 ÖVP vs. FPÖ	Speaks to voter pouching

Interview Coding Protocol Italy:

Theme / Codes	Notes
1. History	
1.1 Geography	
1.2 Military	
1.3 Population	
2. Federal Government	
2.1 Healthcare	
2.1.1 Devolution	
2.1.2 Health Literacy	
2.1.3 Health Rights	
2.1.4 Health Costs	
2.1.5 Health Reforms	
3. Healthcare System	
3.1 Regional	
3.1.1 Variation	Speaks to the general variation in healthcare systems between regions
3.1.2 Lombardy	
3.1.3 Veneto	
3.1.4 Emilia Romagna	
3.2 Hospitals	
3.3 Financing	
3.4 Personnel	
3.5 Waiting Times	

3.6 Freedom of Movement	Speaks to the ability to move freely between the healthcare services of different regions
4. Regions	Speaks to the Italian Regions in general
5. Cities	Speaks to the Italian cities/municipalities
6. Culture	
7. Vaccinations	
8. SIMM	Italian Society of Leadership and Management in Medicine – immensely strong organization that influences policy
9. Immigration	
9.1 Problems	
9.2 Healthcare	
9.3 Legal vs Undocumented	Speaks to the different types of immigrants and the rights they have
9.4 Regions	
9.5 Federal	
10. Welfare Type	Refers to welfare chauvinism, liberal chauvinism, etc.
11. Out group	Any group deemed as being "excluded"
12. Party	
12.1 Italian Party System	
12.2 Lega Nord	
12.3 Social Democrats	
12.4 M5S	
12.5 Fratelli d'Italia	
13. Lega Nord	
13.1 Policy	
13.2 Health	
13.3 Support	
13.4 Regionalism	
13.5 Salvini	Leader of the Lega since 2013
15. Corona	
15.1 Leadership	
15.2 Testing	
15.3 Healthcare	
15.4 Hospitals	
15.5 Confusion	
15.6 Communication	
15.7 Personnel	
15.8 Federal Government	
15.9 Regional Government	

Appendix B: Austrian Parliament 1999 to present

21st National Council 1999-2002

The 21st National Council election of 1999 was interesting in that the Social Democratic (SPÖ) party had significantly more votes than any of the other parties represented within the council. This was also the first time that the Christian Democrats (ÖVP) came in 3rd place, beat by the Freedom Party (FPÖ) who increased its vote share by 5,02%.

Initially, coalition talks were held between the SPÖ and the ÖVP, but when the SPÖ refused to give the ÖVP the position of finance minister, the coalition talks ceased and the ÖVP formed a governmental coalition with the FPÖ in 2000. This marked the first time in Austrian history that a populist radical right party (FPÖ) entered into government. Both governmental parties had 52 seats in the National Council giving them the majority in Parliament if they worked together (104). Wolfgang Schüssel (ÖVP) would become the Chancellor. The fact that the SPÖ had more seats (65) than each governmental party individually made the opposition somewhat stronger than usual.

The policies that were relevant during this election period can be summarized as: the FPÖ led by, Jörg Haider, increased its anti-foreigner rhetoric, advocated for a freeze on immigration, took a stronger stance against crime, wanted a 23% flat income tax rate, opposed the enlargement of the EU and more aid for Austrian families with children. The ÖVP was pro EU

and NATO and advocated for a free market economic reform while the SPÖ pushed for Austrian neutrality and stronger state control over the economy (Inter-Parliamentary Union 2013).

22nd National Council 2002-2006

These elections came a year early due to the breakup of the FPÖ and the vice Chancellor of the party Susanne Reiss-Passer stepped down. Shortly after, Parliament voted to dissolve the government and new elections were set (Inter-Parliamentary Union 2013). Because of divisions and coup attempts within the FPÖ, the party lost 34 of their seats. This loss benefited the ÖVP majority greatly, adding 27 to their 52 seats. The ÖVP decided to continue their governmental coalition with the FPÖ surpassing the necessary seat allocation for a coalition by only one seat. Whereas the majority in the previous National Council was 104 for the government coalition, it slipped to 97 during this period signifying an increase in seats for the opposition. Wolfgang Schüssel (ÖVP) continued as Chancellor during this period.

The policy analysis for this election period was very interesting as the ÖVP positioned themselves very far to the right taking on much of the FPÖs platform. The ÖVPs campaign for this election was led against asylum seekers coming into the country for economic reasons (Inter-Parliamentary Union 2013). The SPÖ also repositioned themselves to encompass the neo-liberal positions of the former ÖVP, thereby also shifting right in their ideological stance.

23rd National Council 2006-2008

In 2006, the National Council Election resulted in an unsurprising SPÖ majority (68 seats) with the ÖVP not too far behind (66 seats). The FPÖ increased their seats by three but could no longer be considered as a coalition partner as the total seats (ÖVP and FPÖ) would be

under 96. It is interesting to note that there were two far-right parties participating in this election period the FPÖ as well as the BZÖ (formed by former FPÖ leader Jörg Haider after having split from the FPÖ due to irreconcilable differences in 2005). After three months of negotiations, a grand coalition SPÖ/ÖVP was formed in 2007 with Alfred Gusenbauer (SPÖ) as Chancellor of Austria. This coalition was shaky from the very beginning disagreeing on everything from health policy to taxes and education (Inter-Parliamentary Union 2013), thus it was not a big surprise that the cooperation was short-lived.

Chancellor Gusenbauer announced that he would step down as SPÖ leader and soon after the ÖVP leader, Wilhelm Molterer, announced that his party would withdraw from the coalition government (Inter-Parliamentary Union 2013). The problem between the two parties began with a disagreement over tax reform and escalated when the SPÖ submitted a proposal to offset inflation. After much bickering back and forth, the National Council voted unanimously to dissolve itself and hold new elections.

The campaign platforms during this election can be summarized as: The ÖVP continued its support for business-friendly tax cuts implemented by Schüssel's government. The SPÖ promised to deal with youth unemployment. The FPÖ called for the expulsion of foreigners from Austria and the BZÖ also supported an anti-immigration platform (Inter-Parliamentary Union 2013).

24th National Council 2008-2013

The collapse of the coalition government SPÖ/ÖVP in 2008 led to new elections 25 months before they were actually due. Despite garnering the worst results since WWII, a new SPÖ/ÖVP coalition was born with 57/51 seats won respectively (Inter-Parliamentary Union

2013) and Werner Faymann (SPÖ) was elected Chancellor of Austria. The FPÖ and the BZÖ were able to increase their seats to 34 and 21 and the Green party trailed behind with 20 seats.

The policy issues surrounding this election were the following: The SPÖ reintroduced its policy project of making the last year of kindergarten compulsory and free of charge. The ÖVP, previously opposing that policy in the previous governing period, announced that it would support the SPÖ's plan as well as fight abuses of asylum rules. Both far-right parties campaigned to end immigration and called for the expulsion of foreigners and asylum-seekers who committed crimes. Heinz Christian Strache, head of the FPÖ, criticized the outgoing coalition government, calling its members "traitors of the people". While Jörg Haider (BZÖ) promised to fight off the "catastrophe of inflation" and provide rent subsidies and free kindergarten (Inter-Parliamentary Union 2013).

25th National Council 2013-2017

The 2013 National Council elections resulted in a very similar outcome to the previous years. The SPÖ and ÖVP seat shares continued to decrease 52/47, the seats acquired by the FPÖ increased to 40, the Greens remained consistent around the mid 20 mark and two new parties joined the political spectrum: Frank Stronach and the NEOS. Despite the increased losses, the SPÖ and ÖVP decided to form once again with Werner Faymann (SPÖ) elected as Chancellor of Austria once more.

The promises made during this election period can be summed up as follows: the SPÖ promised to create more jobs, adopt tax cuts for low earners and tax increases for "millionaires". The ÖVP opposed new taxes and promised to introduce measures to free businesses from red tape. The FPÖ campaigned to leave the European Stability Mechanism bailout fund for ailing

euro zone members, a voice echoed by the FRANK, which also called for a flat rate tax. The NEOS said it would not join a coalition that included the FPÖ, stating that it does not share the party's views on Europe and immigration (Inter-Parliamentary Union 2013).

26th National Council 2017-2019

The 2017 National Council elections brought about a few changes. The SPÖ was able to hold onto its 52 seats while the FPÖ under Strache gained 11 seats resulting in a total of 51 seats for the populist party. After having given the ÖVP a new image (the traditional black color of the party was changed to turquoise) under Sebastian Kurz, the party increased its share of seats for 47 to 61. The Green party did not meet the requirements to make it into parliament due to internal conflict and the splitting of their party, while the NEOS increased their seat share by 1 vote. The new party JETZT under Peter Pilz (formally a member of the Green party) took 7 seats.

The SPÖ and the ÖVP did not want to form a coalition together due to strong political differences and the past governing difficulties as partners. Thus, the ÖVP decided to work with the FPÖ once again and Sebastian Kurz (ÖVP) was named Chancellor of Austria with Strache (FPÖ) as his Vice Chancellor.

While my analysis ends in 2019 as that is when the FPÖ left government, Chancellor Kurz formed a new government in 2020 with the Green Party after the country was led by a technocratic government for almost one year.

Appendix C: Italian Parliament 1996 to Present

Parliament 2018-Present

No political party received the necessary majority of 40% to form a majority parliament, therefore the two biggest winners, 5SM and the center right block (including the PRR party, Lega), had to negotiate a coalition and develop a joint political program (Statsita 2018). Despite the fact that no one party held the parliamentary majority, more than 50% of Parliament is now made up of populists of both Left and Right orientation. Lengthy and unfruitful negotiations between Lega head Matteo Salvini and 5SM Luigi di Maio resulted in a third person nomination for Prime Minister of the country. Giuseppe Conte, a lawyer with no political experience and an independent political orientation was chosen for the job and given the okay by President Mattarella to form a government. Because neither the 5SM or the Lega had the governmental majority, one could say their power was relatively evenly distributed considering that typically one coalition member has the majority and is thus able to nominate the Prime Minister.

Parliament 2013-2018

The clear electoral majority was won by the center-left alliance of the Italy Common Good (IBC) and the Democratic Party (PD). In second place came the center-right alliance under Berlusconi and the anti-establishment 5 Star Movement headed by Beppe Grillo came in third. No political majority was found in the Senate resulting in a Grand Coalition between Italy Common Good, the center right coalition and the PD. Soon thereafter, Berlusconi withdrew his support from the

Grand Coalition and formed his Forza Italia party, leaving the PD to lead the coalition. For the year 2013-2014 there was no majority in Parliament as it was shared between the center-right and center-left thus resulting, once again, in a neutral, Independent Prime Minister. Between 2014 and 2018, the center-right parties left the Grand Coalition, thereby leaving the majority to the Center Left.

Parliament 2008-2013

From 2008 until 2011 Berlusconi's center right coalition had the majority in Parliament and subsequently elected Berlusconi as prime Minister (for the 4th time). In 2011, lasting until the end of the governmental period in 2013, Berlusconi was removed from power and his entire cabinet is replaced with a technocratic government. Thus, the majority in parliament, once again, disappeared.

Parliament 2006-2008

Throughout this period the Social Democratic center left union had the majority and was therefore able to elect the Prime Minister, Romano ProdiThe Prodi government was dissolved by President Napolitano in 2008 after the Senate gave Prodi a vote of no confidence, which is why the general election was called out in 2008.

Parliament 2001-2006

The center right coalitions led by Silvio Berlusconi won the absolute majority in this election. Berlusconi's Forza Italia had become the biggest party in Italian politics during this time (Pasquino 2010), therefore making it easy to appoint Berlusconi as Prime Minister.

Parliament 1996-2001

A snap general election was called in 1996 where the leaders of the center left coalition narrowly defeated Berlusconi's Center Right alliance, thus giving the center left the majority in Parliament. An interesting side note is that Umberto Bossi's Northern League distanced themselves from Berlusconi's center-right coalition and ran alone after having left the Berlusconi cabinet in 1994.

Appendix D: Hypo Alpe Adria Scandal

Timeline of the scandal taken and adapted from (ORF, 2016):

1992 ➔ (net worth €1.87 billion) The province of Carinthia brought Grazer Wechselseits Versicherung (GraWe) on board as a co-owner of the State Mortgage Bank. Shortly thereafter, Wolfgang Kulterer (ÖVP) was made board member of the Bank by governor Zernatto (ÖVP) and converted it into a stock corporation. Jörg Haider (FPÖ) criticized Kulterer's placement because Kulterer came from the Raiffeisenbank (ÖVP controlled). Kulterer expanded the banks presences into the Balkan countries wherein shareholdings are bought, and bank subsidiaries are created.

2005 ➔ (banks net worth €24.2 billion)

2006 ➔ Kulterer is put under pressure and German investor Tilo Berlin (ÖVP) joins with 4,5% through the investment of €125 million from "wealthy private individuals". In March, expensive swap losses are uncovered and the balance sheet for 2004 has to recalculated. It comes up negative. The Financial Market Authority reports the entire management board for falsifying accounts. Kulterer steps down and is replaced by Siegfried Grigg (party unknown), but Kulterer continues to pull strings in the background.

2007 ➔ GraWe announces that it will sell its shares to Tilo Berlin. In May, the bank is sold for €1.62 billion to BayernLB, a deal that was apparently supported by Jörg Haider (FPÖ/BZÖ). Tilo Berlin and those associated with him earn €150 million on the deal and he becomes CEO of the Hypo. This sale was investigated by the Carinthian state parliament but did not reveal any

significant findings. BayernLB holds 50% of the bank's shares, GraWe 26.45%, the province of Carinthia 20%, the Hypo-Alpe-Adria-Employee Foundation 3.33% and Berlin and associates .22%. By November, BayernLB had to invest €440 million (and GraWe €160 million) of fresh capital into its Carinthian subsidiary for the first time

2008 ➔ (net worth €42.3 billion). Further invest by BayernLB were made. Kulterer pleads guilty of falsifying accounts. Due to the financial crisis BayernLB had to invest another €700 million into the Hypo Bank. The bank also received €900 million in participation capital from the province of Carinthia as a bank aid package. The Carinthian shares continue to decrease and are at 12.42%, meaning that BayernLB owned more than 67%.

2009 ➔ Tilo Berlin leaves the group and is replaced by banker Franz Pinkl (ÖVP), who previously resigned from Österreichische Volksbanken AG (ÖVAG). In April, the bank announces a loss of €520 million in 2008. By the fall, house searches take place in Bavaria and Carinthia. The Munich public prosecutor's office suspects that BayernLB paid €400 million too much for the Hypo. In November, the Hypo Group announced that it would post a loss of "well over one billion" in 2009. Thus, the bank needed a new capital injection of around €1.5 billion. BayernLB no longer want to be the only company pumping money into the bank and so the province of Carinthia demands that the Austrian federal government help. The problem is that the capital requirement is estimated at €1.5 to 2 billion euros implying that the balance sheet losses are so large that the Hypo fell below the minimum core capital ratio. The state of Carinthia demands a second aid package from the federal government. The then Finance Minister Josef Pröll (ÖVP) sees the owners as being responsible. Bavaria's governor wants support from the federal government in Austria and Germany. By December, Bavaria's Finance Minister Georg Fahrenschon publicly calls the purchase of Hypo a "mistake". A day later, the rating agency

Moody's lowers the Hypo rating to "junk status". Negotiations for state aid are continue. Bavaria's opposition brings criminal charges against those responsible for Hypo purchases. Tilo Berlin is one of them. Initially, Austria's political leaders emphasized that constructive proposals from the owners to rescue the Hypo must come before federal aid would be given. Likely because a report was released that the Hypo was threatened with risk provisions of €3.1 billion over the next five years, Pröll (ÖVP Finance Minister) announces the nationalization of the Hypo. The previous owners would provide € 1.05 billion in capital and the Austrian federal government would provide up to €450 million. The prosperous internationally active Hypo Alpe Adria Bank was symbolically bought by the Republic of Austria for €3.

2011 ➔ (net losses of €1.6 billion) arrests begin.

Interviewee 1.3 Politician describes the scandal and the FPÖs involvement as follows:

> *Take the Hypo, that is the biggest lie that ever circulated in Carinthia. Carinthia never took on a guarantee (Bürgschaft) for the HYPO, this is a fallacy. Carinthia was the deficiency guarantor. Very important. No liability, no direct liability assumed, rather deficiency guarantor. That means that via the Carinthian Landesholding Gesetz that when HYPO goes into bankruptcy the court orders a liquidator (massenverwalter). The liquidator leads the company and looks to see what liabilities he has. The first liability that the HYPO Kärnten has is the mutual cross-guarantee system of the Landeshypothekenbanken just like the Raiffeisen provincial banks has the Raiffeisen central bank as cross-guarantee. There they have the bond institute (Pfandbriefanstalt) all the provincial HYPOs are a part of this and these provincial HYPOs would have had to send the liquidator 700-800 million € right away. And no one has to know that this was the reason why the federal government got involved. The HYPO upper Austria, the HYPO Salzburg and the HYPO Steiermark make up 60% of all HYPO revenue and these three banks are predominately under the ownership of the Raiffeisen (ÖVP). That means of the 700-800 million €, Raifeissen would have had direct damages up to 500 – 600 million €. That is the reason why Mr. Pröll (ÖVP Finance Minister at the time) initiated an emergency nationalisaton (Notverstaatlichung). I handed in a notification because of this to the public persecutors office that I find this to be a biggest injustice. The liquidator, if he would have claimed these*

guarantees, would have then phased-out the HYPO and when he sold the last pencil then he could have determine the damages, if there are any.
In the end it looks like we might even get something out of this whole thing because right now no one is talking about 32 billion anymore, now its only 9 billion.
And when the liquidator sold the last pencil he would have said now we have damages priced at, I don't know, €5 billion, €8 billion, then he would have had the deficiency guarantor (ausfallsbürge) Land Kärnten, then he would have called the governor and then if I would have been governor, I would have told the liquidator: Yes, I am your deficiency guarantor, but you see in the Landesholding, it says: in the case that the deficiency guarantor should ever be used, the owner of the bank is liable for the damages. This would have first led to the Freistaat Bayern and then the Republic of Austria. So, if this day came and I was governor I would say, yes you are right I am going to call the chancellor of Austria. I would have told him I have 5 billion to pay, you have to pay the damages anyways, don't you want to send the money right away?

Upon asking the interviewee why the case was not presented as described, the interviewee answered:

Because Mr. Pröll and the ÖVP had two interests: 1) to spare the Raiffeisen from paying the 5-6 million and 2) to make Haider and his FPÖ responsible for something for eternity. In fact the SPÖ used the following argument for years: "What do you want the FPÖ in government for? Do you want to make a Carinthia out of it?" This was the most beautiful argument for them against the FPÖ.

Appendix E: Interviews

Austria:

Table D. 1 Interview List Austria

Code #	Code	Date Interviewed	Focus	2nd Focus	3rd Focus
1.1	Health Expert / Official	22.08 18	Carinthia	Austria	
1.2	Political Scientist	18.07.19	Carinthia	Austria	
1.3	Politician	23.08.19	Carinthia	Austria	
1.4	Politician	31.08.19	Carinthia	Austria	
1.5	Politician	16.09.19	Carinthia	Austria	
1.6	Health and Welfare Expert	11.10.19	Austria		
1.7	Health Expert / Official	20.10.19	Austria		
1.8	Politician	21.02.20	Burgenland	Austria	
1.9	Politician	09.06.20	Burgenland		
1.10	Public Health Expert	16.07.20	Austria		
1.11	Public Health Expert	16.07.20	Austria		
1.12	Public Health Expert	16.07.20	Austria		
1.13	Health Expert	04.09.20	Vienna	Austria	
1.14	Health Economics Expert & Advisor	5.10.20	Austria		
1.15	Politician	21.10.20	Burgenland	Austria	Corona
1.16	Health Expert / Official	28.11.18	Austria	Tyrol	
1.17	Medical Prof / Public Health Expert	28.11.18	Austria		

Table D.2 Interview List Italy

Code #	Code	Date Interviewed	Focus	2nd Focus	3rd Focus
2.1	Official for Health, Welfare, Health Integration and Sport	19.06.18	Italy	Lombardy	
2.2	Public Health Expert	19.06.18	Italy	Regions	
2.3	Health Expert / Official	21.06.18	Immigrants	Regions	
2.4	Migrant Expert	22.06.18	Italy		

2.5	Public Health Expert	22.06.18	Italy		
2.6	Medical, Hygiene & Public Health Expert	28.11.18	Italy		
2.7	Medical Professional	28.11.18	Friuli-Venezia-Giulia	Vaccines	
2.8	Medical Professional	28.11.18	Friuli-Venezia-Giulia	Italy	
2.9	Public Health Expert	29.11.18	Italy	Regions	
2.10	Health and Public Health Expert	29.11.18	Italy	Migrants	
2.11	Political Scientist	18.03.20	Italy		
2.12	Medical Professional	22.03.20	Corona		
2.13	Political Scientist and Migration Expert	27.03.20	Regions		
2.14	Political Sociologist	01.04.20	Italy	Migrants	
2.15	Health Economist	18.12.20	Italy	Regions	
2.16	Political Geographer	13.01.21	Lombardy	Veneto	Corona
2.17	Economic Sociologist and Social Policy Expert	20.01.21	Veneto	Lombardy	Corona
2.18	Medical Professional and Public Health Expert	08.02.21	Corona	Lombardy	
2.19	Medical Professional	08.02.21	Corona	Lombardy	
2.20	Public Health Expert	08.02.21	Corona	Lombardy	

Appendix F: Interview Protocol Form

Interviewee Name: _____

Interviewee Title: _____

Interviewee Institution: _____

Thank you for taking the time to participate in this interview. My name is Michelle Falkenbach and I am a doctoral candidate at the University of Michigan School of Public Health. This interview is part of research being conducted for my dissertation. As my earlier email/phone call mentioned, I am interested in learning more how Populist Radical Right (PRR) parties (FPÖ and Lega) impact health and health policy in Austria and Italy. You have been selected because you have been identified as someone who has much knowledge regarding national and subnational policy making. Your expertise will help me better understand if and how the PRR parties impacted health and health policy. All of your responses will be kept anonymous, unless you give me permission to use your name. Before we start, do you have any questions for me?

Interviewee Background

- Can you tell me what your specific role is/was? (politicians)
- Can you tell me what your area of expertise is exactly and how long you have been working in this field? (Political scientists, health experts, researchers, etc.)

Political Perspective (Federal)

- You have been in the federal government for xx years. What can you tell me about the health politics of the FPÖ/Lega?
    - Probe: The FPÖ were able to appoint health ministers during their coalition with the ÖVP in 2000 and again in 2017? Why?
    - Probe: What was their attitude towards privatization and health?
    - Probe: What was their attitude towards the Austrian welfare state?
    - Probe: What was their attitude towards migrants – legal and illegal?

- Usually, we see the SPÖ controlling the health ministry. What would you say is the difference between SPÖ and FPÖ health politics?
    - Probe: How would you say do the health and social policies of the FPÖ change when they are in government?

- What ministries are the most important for the FPÖ/Lega?
    - Probe: What influence does the FPÖ/Lega have on health politics?

- How would you classify the FPÖ/Lega's welfare politics?
    - Probe: Who should benefit?
    - Probe: Would you consider them to be a PRR party?

- What would you say were the differences in governing style between the FPÖ/ÖVP/SPÖ/Greens or Lega/PD/FI/Independents?

- What was the FPÖ/Lega attitude towards migrants?
    - Probe: How did this influence their politics?
    - Probe: Did the Conservative or Social Democratic Party ever try to take on this attitude to steal voters away from the FPÖ/Lega?

Political Perspective (Regional)

- You have been in the regional government for xx years. What can you tell me about the health politics of the FPÖ/Lega?

- How does this differ from other provinces/regions?
    - Probe: Social politics?
    - Probe: Health politics?
    - Probe: Why did the FPÖ/Lega make it into regional government in this region and not in others?

- What political goals do the FPÖ/Lega follow?
    - Probe: What influence does the FPÖ/Lega have on health politics?

- What is the FPÖ/Lega attitude towards migrants?
    - Probe: How does this influence their politics? Specifically, their health and social politics?

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